STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

IN RE: William and Sally Tandet Center for Continuing Care
146 West Broad Street
Stamford, CT 06902

CONSENT ORDER

WHEREAS, Mill River Foundation, Inc. (hereinafter the "Licensee"), has been issued License No. 2327 to operate a Chronic and Convalescent Nursing Home known as William and Sally Tandet Center for Continuing Care (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter the "FLIS") of the Department conducted unannounced inspections on various dates commencing on April 28, 2008 and concluding on May 8, 2008; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated June 11, 2008 (Exhibit A – copy attached); and

WHEREAS, a conference regarding the June 11, 2008 violation letter was held between the Department and the Licensee on May 14, 2008; and

WHEREAS, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Joan Leavitt its Section Chief, and the Licensee, acting herein and through Julie Mittleider, its President hereby stipulate and agree as follows:

1. The Licensee shall agree not to acquire any additional ownership interest in a healthcare facility licensed by the Department.

2. The Licensee shall execute a contract with a Quality Assurance Consultant within two (2) weeks of the effective date of this Consent Order. The Quality Assurance Consultant shall conduct and submit to the Department an assessment of the Quality Assurance Program (QAP) utilized by the facility and identify areas that need remediation. The Quality Assurance Consultant shall:
   a. Establish and assist in implementing a quality assurance program that shall review systems within the facility and the ability of the QAP to identify and address issues;
   b. Provide the facility with oversight and resources to implement a responsible and responsive QAP; and
   c. Attend QAP meetings to identify if the facility has implemented recommendations.
3. The Quality Assurance Consultant shall provide monitoring every month for a minimum of six (6) months of the facility's response to quality of care issues identified and ensure that quality of care problems are being appropriately addressed and corrected unless the Department identifies through inspections that a longer time period is necessary to ensure substantial compliance with applicable federal and state statutes and regulations.
4. The Licensee shall execute a contract with an Independent Nurse Consultant (INC) approved by the Department within two (2) weeks of the effective date of this Consent Order. The INC's duties shall be performed by a single individual unless otherwise approved by the Department. The Licensee shall incur the cost of the INC.
5. The INC shall function in accordance with the FLIS' INC Guidelines (Exhibit B - copy attached). The INC shall be a registered nurse who holds a current and unrestricted license in Connecticut. The Registered Nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.
6. The INC shall provide consulting services for a minimum of six (6) months at the Facility unless the Department identifies through inspections that a longer time period is necessary to ensure substantial compliance with applicable federal and state statutes and regulations. The INC shall be at the Facility thirty-two (32) hours per week and arrange his/her schedule in order to be present at the Facility at various times on all three shifts including holidays and weekends. The Department will evaluate the hours of the INC at the end of the six (6) month period and may, in its discretion, reduce or increase the hours of the INC and/or responsibilities, if the Department determines the reduction or

increase is warranted. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Consent Order.

7. The INC shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the patients and to secure compliance with applicable federal and state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
8. The INC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within two (2) weeks of execution of a contract with the Licensee.
9. The INC shall confer with the Licensee's Administrator, Director of Nursing Services, Medical Director, Quality Assurance Consultant and other staff determined by the INC to be necessary to the assessment of nursing services and the Licensee's compliance with federal and state statutes and regulations.
10. The INC shall make recommendations to the Licensee's Administrator, Director of Nursing Services, Quality Assurance Consultant and Medical Director for improvement in the delivery of direct patient care in the facility. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s), the Department, after meeting with the Licensee and the INC shall make a final determination, which shall be binding on the Licensee.
11. The INC shall submit weekly written reports to the Department documenting:
    a. The INC's assessment of the care and services provided to patients;
    b. The Licensee's compliance with applicable federal and state statutes and regulations; and
    c. Any recommendations made by the INC and the Licensee's response to implementation of the recommendations.
12. Copies of all INC reports shall be simultaneously provided to the Licensee, Administrator, Medical Director, Director of Nurses and the Department.
13. The INC shall have the responsibility for:
    a. Assessing, monitoring, and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses, nurse aides, and orderlies and implementing prompt training and/or remediation in any area in which a staff member

demonstrated a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;

b. Assessing, monitoring, and evaluating the coordination of patient care and services delivered by the various health care professionals providing services;

c. Recommending to the Department an increase in the INC's contract hours if the INC is unable to fulfill the responsibilities within the stipulated hours per week; and

d. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letter dated June 11, 2008. (Exhibit A).

14. The INC, the Licensee's Administrator, and the Director of Nursing Services shall meet with the Department every six (6) weeks for the first three (3) months after the effective date of this Consent Order and thereafter at twelve (12) week intervals throughout the tenure of the INC. The meetings shall include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with applicable federal and state statutes and regulations.

15. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the INC and the Department, upon request.

16. The Department shall retain the authority to extend the period the INC functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations. Determination of substantial compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department.

17. Within fourteen (14) days of the execution of this Consent Order the Director of Nurses shall develop and/or review and revise, as necessary, policies and procedures related to physical assessment of patients with pressure ulcers, pressure ulcer prevention and treatment, documentation and tracking of pressure ulcers, care planning, interventions pertinent to pressure ulcers, and turning and repositioning of patients.

18. Within thirty (30) days of the effect of the Consent Order all Facility nursing staff shall be inserviced, to the policies and procedures identified in paragraph number seventeen (17).

19. The Facility's medical staff shall review all policies and procedures related to skin integrity and shall document their examinations of all patients relative to impaired skin integrity.
20. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Director of Nursing Services, shall ensure substantial compliance with the following:
    a. Sufficient nursing personnel are available to meet the needs of the patients;
    b. Patients are maintained, clean, comfortable and well groomed;
    c. Patient treatments, therapies and medications are administered as prescribed by the physician and in accordance with each patient's comprehensive care plan;
    d. Patient assessments are performed in a timely manner and accurately reflect the condition of the patient;
    e. Each patient care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;
    f. Nurse aide assignments accurately reflect patient needs;
    g. Each patient's nutritional and hydration needs are assessed and monitored in accordance with his/her individual needs and plan of care;
    h. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, decline in skin integrity, presence of any infection, and deterioration of mental, physical, nutritional, and/or hydration status. In the event that the personal physician does not adequately respond to the patient's needs or if the patient requires immediate care, the Medical Director is notified;
    i. Patient's with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice;
    j. Necessary supervision and assistive devices are provided to prevent accidents;
    k. Policies and procedures related to dehydration prevention will be reviewed and revised to include, in part, notification of the attending physician or medical director when the patient's fluid intake does not meet their assessed needs; and

l. Patient injuries of unknown origin are thoroughly investigated, tracked, and monitored.

21. Effective upon the execution of this Consent Order, the Licensee shall appoint a free floating Registered Nurse Supervisor on each shift whose primary responsibility is the assessment of patients and the care provided by nursing staff. A nurse supervisor shall maintain a record of any patient related issue(s) or problem(s) identified on his or her shift and a notation as to the subsequent action taken to resolve the problem(s). Such records shall be made available to the Department upon request and shall be retained for a two (2) year period.
22. Individuals appointed as Nurse Supervisor shall be employed by the facility, shall not carry a patient assignment and shall have previous experience in a supervisory role.
23. Nurse Supervisors shall be provided with the following:
    a. A job description which clearly identifies the supervisor's day-to-day duties and responsibilities;
    b. A training program which clearly delineates each Nurse Supervisor's responsibilities and duties with respect to patient and staff observations, interventions and staff remediation;
    c. Nurse Supervisors shall be supervised and monitored by a representative of the Licensee's Administrative Staff, (e.g. Director of Nursing Service or Assistant Director of Nursing Service) to ensure the Nurse Supervisors are functioning in accordance with this Consent Order and state and federal requirements. Said administrative supervising and oversight shall be provided on all three (3) shifts on an irregular schedule of visits. Records of such administrative visits and supervision shall be retained for the Department's review; and
    d. Nurse Supervisors shall be responsible for ensuring that all care is provided to reside patients by all caregivers is in accordance with individual comprehensive care plans.
24. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe.
25. The Licensee shall maintain minimum staffing ratios of seven (7) patients to one (1) nurse aide between the hours of 8:00 AM to 4:00 PM, twelve (12) patients to one (1)

nurse aide between the hours of 4:00 PM to 12:00 AM and twenty (20) patients to one (1) nurse aide between the hours of 12:00 AM to 8:00 AM.

26. The Licensee shall maintain minimum licensed staffing ratios of one (1) licensed nurse to twenty (20) patients on the 8:00 AM-4:00 PM shift, (1) one licensed nurse to twenty five (25) patients on the 4:00 PM-12:00 AM shift and one (1) licensed nurse to thirty (30) patients on the 12:00 AM- 8:00 AM shift.
27. The Licensee's Quality Assurance Program (QAP) shall meet at least monthly to review and address the quality of care provided to patients and, if applicable, implement remediation measures. Membership shall at a minimum, include the Administrator, Director of Nurses, Infection Control Nurse, Nurse Supervisors, and the Medical Director. Minutes of the QAP meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.
28. In accordance with Connecticut General Statute Section 19a-494 (a) (5), the license of The William and Sally Tandet Continuing Care Center is placed on probation for the period of the term of this consent order.
29. The Licensee shall pay a monetary penalty to the Department in the amount of four (4) thousand dollars ($4,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within two (2) weeks of the effective date of this Consent Order. The money penalty and any reports required by this document shall be directed to:

Maureen Klett, R.N., C., M.S.N.,
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308 MS #12HSR
Hartford, CT 06134-0308

30. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent

Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.

31. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
32. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
33. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
34. Should the Licensee not be able to maintain substantial compliance with the requirements of the Consent Order the Department retains the right to issue charges including those identified in the June 11, 2008 violation letter referenced in this document.
35. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

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Licensee: Mill River Foundation, Inc.

WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

Mill River Foundation, Inc - Licensee

October 21, 2008
Date

By: _____
Julie Mittleider, President

STATE OF Georgia)

County of Fulton) ss October 21, 2008

Personally appeared the above named President, J. Mittleider and made oath to the truth of the statements contained herein.

MARC ROSEN
Notary Public, Fulton County, Georgia
My Commission Expires April 11, 2009

My Commission Expires: _____
(If Notary Public)

Notary Public	[x]
Justice of the Peace	[ ]
Town Clerk	[ ]
Commissioner of the Superior Court	[ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

10/23/08
Date

By: _____
Joan D. Leavitt, R.N., M.S., Section Chief
Facility Licensing and Investigations Section

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 43

June 11, 2008

Mr. David Guasta, , Administrator
Wm & Sally Tandet Ctr For Cont
146 W Broad Street
Stamford, CT 06902

Dear Mr. Guasta:

Unannounced visits were made to Wm & Sally Tandet Ctr For Cont on April 28, 29, 20, May 1, 2, 3, 5, 6 and 7, 2008 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple complaints and a certification survey.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for June 23, 2008 at 1:30 PM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violation(s) to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Rosella Crowley, RN LBSC

Rosella Crowley, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

RAC:zbj

c. Director of Nurses
Medical Director
CT #7215, CT#8016

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

EXHIBIT A

DATES OF VISITS: April 28, 29, 30, May 1, 2, 3, 5, 6 and 7, 2008

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2)(L).

1. Based on clinical record reviews, and interviews for 33 sampled residents (Residents #2, 3, 9, 16, 35, 36, 37, 40, 41, 46, 47, 51, 53, 56, 58, 61, 66, 70, 80, 83, 95, 110, 116, 130, 140, 149, 151, 164, 169, 172, 179, 255, 264), the facility failed to ensure that the resident's physician was contacted when the resident failed to receive medications and/or treatments as ordered, and/or when a resident experienced a change in condition.
    a. Resident #35's diagnoses included acute myocardial infarction, rhabdomyolysis, congestive heart failure, and arthritis. Physician orders dated 4/3/08 directed the administration of Aspirin 81 mg daily (10 AM), Depakote 125 mg twice a day (10 AM), Lasix 40 mg daily (10 AM), Potassium 20 meq daily (10 AM), and Metoprolol 12.5 mg twice a day (10 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications and/or doses as ordered by the physician. The physician and/or medical director were not notified of the above medication omissions.
    b. Resident #140's diagnoses included cardiac arrhythmias and hypertension. Physician orders dated 4/4/08 directed the administration of Cardizem CD 120 mg daily (9 AM), Folic Acid 1 mg daily (9 AM), and Toprol XL 200 mg daily (9:30 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician. The physician and/or medical director were not notified of the above medication omissions.
    c. Resident #175's diagnoses included seizure disorder, atrial fibrillation, diabetes and dementia. Physician orders dated 3/3/08 directed the administration of Dilantin 300 mg daily (9 AM), Provigil 100 mg daily (9 AM), Bactrim SS daily (9 AM), Tylenol 1000 mg twice a day (9 AM), and Norvasc 10 mg daily (9:30 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician. The physician and/or medical director were not notified of the above medication omissions.
    d. Resident #61's diagnoses included cirrhosis, diabetes, stroke and depression. Physician orders dated 3/7/08 directed the administration of Keppra 500 mg twice a day (9 AM), Folic acid 1 mg daily (9:30 AM), Zestril 40 mg daily (9:30 AM), Plavix 75 mg daily (9:30 AM), and Zoloft 100 mg daily (9:30 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician. The physician and/or medical director were not notified of the above medication omissions.
    e. Resident #46's diagnoses included stroke and congestive heart failure. Physician orders dated 3/18/08 directed the administration of Zestril 20 mg daily (10 AM), and Coreg 12.5 mg two tablets twice a day (10 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician. The physician and/or medical director were not notified of the above medication omissions.
    f. Resident #41's diagnoses included Alzheimer's disease, Parkinson's disease, and

depression. Physician orders dated 3/12/08 directed the administration of Zoloft 50 mg daily (9 AM) and Sinemet 25/100 two tablets twice a day (9 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician. The physician and/or medical director were not notified of the above medication omissions.

g. Resident #53's diagnoses included Alzheimer's disease, an transient ischemic attacks. Physician orders dated 3/5/08 directed the administration of Namenda 10 mg twice a day (10 AM), and Plavix 75 mg daily (10 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician. The physician and/or medical director were not notified of the above medication omissions.

h. Resident #36's diagnoses included diabetes, dementia, and hypertension. Physician orders dated 4/2/08 directed the administration of Amitiza 24 mcg twice a day (10 AM), Toprol XL 100 mg daily (10 AM), and regular insulin via a sliding scale based on blood sugar checks to be done 4 times a day (11:30 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses and/or blood sugar checks as ordered by the physician. The physician and/or medical director were not notified of the above medication omissions.

i. Resident #172's diagnoses included depression, and glaucoma. Physician orders dated 4/3/08 directed the administration of Alphagan eye drops twice a day (9 AM), Timolol eye drops twice a day (9 AM), and Metoprolol 25 mg 1/2 tabs twice a day (9 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician. The physician and/or medical director were not notified of the above medication omissions.

j. Resident #51's diagnoses included depression, stroke, atrial fibrillation, hypertension, and constipation. Physician order dated 4/3/08 directed the administration of Dulcolax 5 mg tablet daily (1 PM), Digoxin 0.125 mg daily (1 PM), Cardizem CD 240 mg daily (1 PM), Lisinopril 20 mg daily (1 PM), Plavix 75 mg daily (1 PM), Lasix 20 mg daily (1 PM), and Amitiza 24 mcg daily (1 PM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician. The physician and/or medical director were not notified of the above medication omissions.

k. Resident #58's diagnoses included ulcerative colitis, hypertension and cardiac arrhythmia. Physician orders dated 2/26/08 directed the administration of Diovan 80 mg daily (10 AM), Lexapro 10 mg daily (10 AM), Vitamin B12 1,000 mcg daily (10 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician. The physician and/or medical director were not notified of the above medication omissions.

l. Resident #149's diagnoses included diabetes and Alzheimer's disease. Physician orders dated 4/5/08 directed the administration of Risperdal 0.25 mg twice a day (9 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician. The physician and/or medical director

were not notified of the above medication omissions.

m. Resident #70's diagnoses included stroke, dementia, diabetes, and coronary artery disease. Physician orders dated 3/13/08 directed the administration of Atenolol 50 mg three times a day (2 PM), Quinapril 40 mg daily (9 AM), and Hydrochlorothiazide 12.5 mg daily (9 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician. The physician and/or medical director were not notified of the above medication omissions.

n. Resident #116's diagnoses included dementia with psychosis, Alzheimer's disease, and osteoporosis. Physician orders dated 4/12/08 directed the administration of Baclofen 10 mg every eight hours (2 PM), Tylenol 1000 mg every 8 hours (2 PM), and Benadryl 12.5 mg every twelve hours (9 AM for a rash). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician. The physician and/or medical director were not notified of the above medication omissions.

o. Resident #264's diagnoses included hypertension, stroke, dysphagia and gastrostomy tube placement. Physician orders dated 4/8/08 directed the administration of Aspirin 325 mg daily (9AM), Zocor 20 mg daily (9 AM), and Prevacid 20 mg daily (9 AM). On 4/20/08 during the 8 AM-4PM shift, the resident did not receive the above noted medication doses.

p. Resident #179's diagnoses included aspiration pneumonia. Physician orders dated 4/4/08 directed the administration of Prostat 30 ml twice a day (9AM), Trazodone 25 mg twice a day (10 AM), Labetalol HCL 100 mg daily (9 AM), Lexapro 10 mg daily (9AM), Patanol eye drops twice a day (9 AM), and on 4/11/08, orders directed Nystatin swab to mouth and tongue four times a day (9 AM and 1 PM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive any of the above noted medication doses. The physician was not notified of the above medication omissions.

q. Resident #169's diagnoses included dementia with psychosis, diabetes and seizures. Physician orders dated 3/12/08 directed the administration, in part, of Ibuprofen 600 mg three times a day (12 noon), Aspirin 81 mg daily (10 AM), Sinemet 10/100 twice a day (10 AM), Lasix 40 mg daily (10 AM), Lexapro 10 mg daily (10 AM), Potassium 10 meq daily (10AM), and Mysoline 50 mg daily at 10 AM. On 4/20/08 during the 8 AM to 4 PM shift, the resident failed to receive the above noted doses of medications as ordered by the attending physician. The resident's physician was not notified of the medication omissions.

r. Resident #164's diagnoses included stage IV pressure sore of the right buttock, dementia, and Parkinson's disease.

    i. Physician orders dated 3/14/08 directed the administration, in part, of Sinemet 25/100 twice a day (10 AM), Namenda 10 mg twice a day (10 AM), Plavix 75 mg every day (10 AM), Zocor 20 mg daily (10 AM), Oxycodone 5 mg, 1/2 tab twice a day (9AM), and Tylenol 1000 mg every 8 hours (2 PM). On 4/20/08 during the 8 AM-4PM shift, the resident did not receive the above medications as ordered by the attending physician.

ii. Resident #164's physician orders dated 3/14/08 directed to float the left heel at all times, and to check positioning and skin condition every shift. Physician orders dated 4/9/08 directed to irrigate the right buttock stage IV pressure sore with normal saline and to pack with saline moistened gauze twice a day for 14 days. On 4/20/08 during the 8 AM-4PM shift, the resident failed to receive the treatments above as ordered by the physician. The resident's attending physician was not notified of the medication and/or treatment omissions.

s. Resident #151's diagnoses included Alzheimer's disease grand mal seizures, and failure to thrive. Physician orders dated 4/19/08 directed the administration of Pronutra one bottle twice a day (10 AM) and Depakote 250 mg every 8 hours (2 PM). On 4/20/08 during the 8 AM - 4 PM shift, the resident did not receive the above noted medication and/or supplement. The resident's physician was not notified of the omissions.

t. Resident #130's diagnoses included anxiety, Alzheimer's disease and chronic obstructive pulmonary disease. Physician orders dated 4/3/08 directed the administration of Xanax 0.25 mg every morning at 9 AM, Lexapro 10 mg, every morning at 9 AM, Vitamin C 500 mg every morning at 9 AM, Namenda 10 mg every morning at 10 AM, and Seroquel 50 mg every morning at 10 AM. On 4/20/08 during the 8 AM - 4 PM shift, the resident did not receive the medications listed above as ordered by the physician.

u. Resident #110's diagnoses included stroke, and depression. Physician orders dated 1/25/08 (please also refer to failure of physician to visit timely, F387) directed the administration of Aspirin 81 mg daily at 9 AM, Zoloft 50 mg daily at 9 AM, and barrier topically to both heels twice a day including once on the 8 AM to 4 PM shift. On 4/20/08 the resident failed to receive the medications and treatment as ordered by the attending physician. The resident's physician was not notified of the omissions.

v. Resident #95's diagnoses included stage four pressure sore, seizure disorder, and dementia.

i. Resident #95's physician orders dated 4/3/08 directed the administration of Dilantin 100mg every 12 hours (9AM), Pronutra mixed with 180 cc of water via gastrostomy tube (G-tube) twice a day (9 AM), 200 cc of water flushes via G-tube four times a day (at 12 noon), and bolus tube feedings with Jevity four times a day (10 AM and 2 PM). On 4/20/08 the resident failed to receive the above medications and/or nutrition as ordered by the physician.

ii. Resident #95's physician orders dated 4/3/08 directed cleansing of the G-tube site twice a day followed by the application of Bactroban. Physician orders dated 4/17/08 directed a daily treatment to the stage IV pressure sore on the left hip of irrigation with normal saline followed by packing the wound with Iodophor gauze. On 4/20/08 during the 8 AM - 4 PM shift, the resident did not receive the treatments as prescribed by the attending physician. On 4/24/08, the APRN assessed the wound and changed the treatment order to Dakin's solution packing twice a day although the measurement of the wound had not changed.

w. Resident #83's diagnoses included diabetes, hypertension, and aspiration pneumonia.

Physician orders dated 4/18/08 directed the resident receive Duoneb four times a day (9 AM and 1 PM) for 7 days. Physician orders dated 4/17/08 directed that the resident receive Reglan 5 mg three times a day with meals (11AM), Starlix 60 mg three times a day before meals (11 AM), Cosopt eye drops twice a day (10 AM), Cymbalta 60 mg daily (10 AM), Lasix 20 mg daily (10 AM), Metoprolol 25 mg twice a day (10 AM), Namenda 5 mg twice a day (10 AM). On 4/20/08 during the 8 AM-4 PM shift, the resident did not receive the above medication doses as ordered by the attending physician. The resident's physician was not notified of the medication omissions.

x. Resident #82's diagnoses included stroke, dysphagia, pressure sores, and pneumonia. Physician orders dated 4/3/08 directed treatments including incentive spirometry three times a day at 9 AM and 1 PM, and to assess the resident's oxygen saturation every shift and maintain it over 90%. On 4/20/08 during the 8 AM-4 PM shift the resident did not receive the above noted assessment and/or treatment. The resident's attending physician was not notified of the above omissions.

y. Resident #66's diagnoses included pneumonia, dysphagia, diabetes, hypertension, and colostomy. Physician orders dated 3/18/08 directed staff to provide colostomy care every shift and to apply "No Sting Barrier" to the area surrounding the ostomy site every shift. On 4/20/08 during the 8 AM-4 PM shift, the resident failed to receive the treatments as ordered by the physician. The resident's physician was not notified of the treatment omissions.

z. Resident #56's diagnoses included dementia, stroke, diabetes, congestive heart failure, and depression. Physician orders dated 4/3/08 directed the administration of Lasix 40 mg daily (10 AM), Lisinopril 20 mg daily (10 AM), Plavix 75 mg daily (10 AM), and Celexa 20 mg once a day (10 AM). On 4/20/08 during the 8 AM-4PM shift, the resident did not receive the above noted medications as ordered by the physician. The physician was not notified of the medication omission.

aa. Resident #47's diagnoses included stroke, Parkinson's disease, and severe mental retardation. Physician orders dated 4/3/08 directed the administration of Sinemet 25/100 four times a day (9 AM and 1 PM), Comtan 200 mg four times a day (9 AM and 1 PM), Requip 2 mg three times a day (9 AM and 1 PM), Aspirin 325 mg daily (9 AM), Depakote 125 mg every 12 hours (10 AM), and Ativan 0.75 mg daily (10 AM). On 4/20/08 during the 8 AM-4PM shift, the resident did not receive the above noted medications. The attending physician was not notified of the medication omissions.

ab. Resident #40's diagnoses included dehydration, and hip fracture. Physician orders dated 2/26/08 directed that the resident receive Reglan 5 mg twice a day before breakfast and lunch (7:30 AM and 11:30 AM), and Quinapril 20 mg daily (10 AM). On 4/20/08 during the 8 AM - 4 PM shift, the resident did not receive the above medications as ordered by the physician. The physician was not notified of the omissions.

ac. Resident #16's diagnoses included hypertension, osteoarthritis, and constipation. Physician orders dated 3/26/08 directed the administration of Tylenol 1,000mg three times a day (9AM and 1 PM), Colace 100 mg twice a day (9 AM), Metoprolol 25 mg, 1/2 a tablet twice a day (10 AM), and a Lidoderm patch to the right knee apply at 9 AM.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

On 4/20/08 during the 8 AM - 4 PM shift, the resident did not receive the above noted medications. The physician was not notified of the omissions.

ad. Resident #9's diagnoses included dementia, stroke, hypoxia with respiratory failure, and seizures. Physician orders dated 4/3/08 directed the administration of Dilantin 100 mg twice a day (9 AM), Prostat 30 ml daily (9 AM), and Colace 100 mg three times a day (9 AM and 1 PM). On 4/20/08 during the 8 AM -4 PM shift, the resident did not receive the above noted medications as ordered by the physician. The physician was not notified of the above noted medication omissions.

ae. Resident #3's diagnoses included myxedema, hypertension, and dementia. Physician orders dated 4/3/08 directed the administration of, in part, Lasix 40 mg daily at 9 AM, Namenda 5 mg twice a day including 9 AM, and Risperdal 0.25 mg twice a day including 9 AM. On 4/20/08 during the 8 AM-4 PM shift, the resident failed to receive the medications above as directed by the physician. The resident's attending physician was not notified of the medication omissions.

af. Resident #2's diagnoses included Parkinson's disease and depression. Physician orders dated January 10, 2008 directed the administration of Sinemet 25/100 four times a day at 9 AM and 1 PM, Zoloft 100 mg at 9 AM, Flovent 110 mcg inhaler at 10 AM (every 12 hours), Os-Ca; 250+D two tablets at 9AM and 1 PM (four times a day), and Aspirin 81 mg daily at 9 AM. On 4/20/08, Resident #2 did not receive the above directed medications as ordered on the 8 AM-4 PM shift. The physician was not contacted regarding the omitted medications.

Interviews with residents, families, and facility staff noted that on 4/20/08, the 4th floor did not have a licensed nurse on duty at all times. Investigation and interview with the supervisor on 4/30/08 at 12 PM noted that she had volunteered to work the 4PM-12 AM shift because there were very few nurses scheduled. Due to call outs and the inability to get any nurses to come in, she had to stay overnight to cover a lack of staffing on the 12 AM-8 AM shift. She noted that the day shift had only 3 nurses scheduled, where 5 should have been scheduled. An agency nurse then failed to show for work at 8 AM leaving 3 floors with only 2 agency supplied LPN's. The supervisor indicated that she called everyone on staff, the agencies, the director of nursing and the assistant director of nursing and failed to find anyone who would come in to work. The administrator's phone number was not available to her. She indicated that she was so tired that she had to put her head down for a while and had difficulty reading the kardexes to administer medications. The supervisor noted that the DNS informed her that she would be in to relieve her at about 11 AM. She further indicated that she attempted to give the respiratory, cardiac and diabetic medications, but was unable to complete a medication pass on all the residents and did not do any of the prescribed treatments for the shift. She noted that it was not until after 2 PM sometime that the DNS came to the facility to relieve her.

Interviews with the DNS on 4/20/08 at 11:35 AM noted that she did not call any

of the physicians and/or the medical director for direction on the omitted medications, did not administer any of the once a day medications or 2 PM medications, and did not do any of the treatments upon arrival at the facility.

ag. Resident #37's diagnoses included chronic obstructive pulmonary disease (COPD), emphysema and bronchitis. An initial assessment dated 03/18/08 identified the resident as having no short and/or long term memory problems and required limited assistance with activities of daily living (ADL). Resident care plan dated 03/14/08 identified a problem with alteration in respiratory status and ineffective breathing related to COPD and bronchitis. Interventions included to administer aerosols/brocho-dilators as ordered and to monitor the effectiveness. Physician orders dated 4/4/08 directed to administer Ventolin MDI two (2) puffs and Atrovent HFA MDI two (2) puffs by mouth three times per day. Observation on 4/28/08 noted RN #1 administrating medications to resident #37. Further observation noted Resident #37 state to RN #1 " I am sick", "my stomach hurts - I need to have a bowel movement or throw up". RN #1 was then observed to continue attempting to administer the medications. Resident #37 was then noted to say "your still going to give me those pills?" RN#1 was then observed to say yes and administer the medications and was then noted to leave the resident without assessing the resident. An interview and review of #37's clinical record with the ADNS and APRN on 04/29/08 at 12:03 PM failed to provide evidence that an assessment and/or physician notification had been conducted and/or documented. The ADNS further indicated that it was the facility policy to document complete assessments of resident's complaints of discomfort.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (g) Reportable Events (6) and/or (j) Director of Nurses (2).

2. Based on reviews of the clinical records, facility documentation and staff interviews for two of three sampled residents (Residents #265, #172) with injuries of unknown origin, the facility failed to conduct thorough investigations to attempt to determine the cause of the injury and prevent further injuries. The findings include:

   a. Resident #265's diagnoses included hemorraghic stroke and Alzheimer's disease. The assessment dated 6/25/07 identified that the resident was cognitively impaired, totally dependent on staff for transfer, dressing, personal hygiene and bathing, required extensive assistance for bed mobility, and had limited range of motion of the upper and lower extremities bilaterally. The care plan dated 7/19/07 noted that the resident was at risk for alteration in skin integrity. Interventions included to turn and position the resident every 2 to 3 hours and to report any open areas. Nurse's notes dated 8/18/07 identified that the resident had a 3 cm by 2 cm open area on the front of the left shin. An X-ray report dated 9/10/07 identified that the resident had a fracture of the distal portion of the first phalange of the left second toe.
   Interview with the Director of Nursing on 5/2/08 at 10:50 AM identified that although an investigation had been conducted at the time of injuries, the statements of facility

staff and results of the investigation could not be located in the facility. Facility documentation dated 9/12/08 identified that the fractured toe may have been related to a Hoyer lift transfer that also resulted in the abrasion/open area of the left shin.
Interviews with LPN # 4 on 5/2/08 at 11:50 AM, MD#1 on 5/2/08 at 4:30 PM, and RN #7 on 5/8/08 at 1:50 PM identified that although the resident was basically immobile, the resident had restless movements of the lower extremities. Further interview with the Director of Nursing on 5/8/08 at 2:15 PM noted that the former DNS had done the investigation which could explain why the investigations differed. The DNS was unable to provide evidence that an investigation had been initiated after the two injuries were discovered.

b. Resident #172's diagnoses included status post dehydration, pulmonary embolism, filter implantation, history of depression, and hiatal hernia. The assessment dated 1/08/08 identified that the resident was moderately cognitively impaired, and required total assistance of two staff for transfer and locomotion. The care plan dated 1/10/08 identified a problem related to immobility. Interventions included to transfer safely with assistance from two persons. Nurse's notes by the Nurse Supervisor dated 4/11/08 at 5:30 PM documented that the resident was observed with a skin tear measuring 0.9 cm x 0.5 cm x 0.3 cm, to the right ankle. The resident was sent to the hospital and returned with five stitches. Facility documentation noted that when the resident was given evening care and socks were removed the laceration was noted by the 4 PM to 12 midnight NA#5. The investigation concluded that the resident's transfer status is assist of two, during transfer the resident might have accidentally hit the legs against the wheelchair foot rest resulting in a laceration to the shin/ankle. Although the investigation included a statement from NA#5 the interview failed to address the method of transfer used by the NA. Interview on 5/01/08 at 10:15 PM with Nurse Aide #5 noted that she transferred the resident back to bed by herself just before dinner. She noted she knew the assignment directed for two staff but she knows that the resident could stand, that she had been taking care of the resident all week and she used her judgment. This night the resident held herself up.
Interview on 5/01/08 at 9:32 AM with the DNS noted that the investigation concluded the skin tear happened during transfer, possibly bumped, as dried blood was noted on the sock. Interview on 5/02/08 at 9:00 AM with the Director of Rehabilitation Services noted that an object, something was in the way to cause the skin tear. She also noted that the resident should have been an assist of two to transfer for safety for the resident and the staff. Interview on 5/02/08 at 11:00 AM and review of the NA#5 interview regarding transfer with one assist with the DNS noted that investigation interview with the 4 PM to 12 midnight NA#5 was done by the evening supervisor and that the DNS proceeded with the investigation of the other staff.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (s) Social Work (2).

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

3. Based on clinical record review, review of facility documentation, and interviews for the only sampled resident who eloped (Resident #143), the facility failed to ensure that residents with adjustment problems related to placement in the nursing facility, received social service assessment and/or interventions to assist in the adjustment. The findings include:
    a. Resident #143 was admitted to the facility on 11/11/07 with diagnoses that included alcohol dependency and fall with rib fractures. The resident was being followed by Elderly Protective Services (EPS) and admitted to the facility while a suitable place to live was researched by EPS. On 11/12/07 during the 12 AM to 8 AM shift, nurse's notes identify that the resident was restless and wandering the halls. The resident was noted going into other resident's rooms and had to be redirected. At 7:30 AM nurse's notes identify that the resident was noted to be missing from the unit. The supervisor was notified and a missing person policy initiated. Subsequent nursing notes for 11/12/08 indicated that the resident returned to the facility, but did not want to stay. The resident became agitated and left the facility without a discharge plan on 11/17/08. The police were notified. Interview and review of the clinical record and facility documentation with the DNS on 5/1/08 at 11 AM noted that the facility did not have a social worker at the time of the resident's admission/elopement and that is probably why there were no notes/assessments by a social worker regarding the resident's discharge needs/elopement.

The following are violations of the Regulatons of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(H).

4. Based on clinical record reviews, observations and staff interviews for two sampled residents (Residents #25, #263), the facility failed to conduct a comprehensive assessment of the resident's needs related to continence, and/or nutrition. The findings include:
    a. Resident #25's diagnoses included peripheral vascular disease. An assessment dated 2/14/08 identified the resident to be without cognitive impairment and totally dependent on staff for activities of daily living including toileting. The resident was noted at that time to be frequently incontinent of urine, but continent of bowel. Nursing progress notes dated 4/8/08 noted that the resident had been readmitted to the facility from the hospital secondary to amputation of a necrotic toe. The readmission nursing assessment dated 4/8/08 identified that the resident was incontinent of bladder as well as bowel upon return from the hospital. Nursing progress notes dated 4/16/08 identified that the resident had a new stage two pressure sore on the buttocks. Observation of the resident while receiving morning care on 5/1/08 at 9:35 AM noted the resident to be incontinent of urine and stool. Interview with the nurse aide at that time who was providing the care, identified that prior to hospitalization, the resident utilized the toilet with occasional episodes of incontinence. She further noted that upon return from the hospital the resident was totally incontinent of bowel and bladder. Review of the clinical record on 4/30/08 at 11:30 AM with the charge nurse failed to provide evidence that the resident's bowel/bladder function/decline had been re-assessed after returning

from the hospital on 4/8/08. According to the charge nurse, it is facility policy to assess a resident upon admission and when a decline in bowel and bladder function is identified.

b. Resident #263 was admitted to facility on 04/11/08 with diagnoses that included cerebral vascular accident (CVA), dementia and de-conditioning. An admission assessment dated 04/15/08 identified the resident was severely cognitively impaired, was totally dependent on facility staff for all activities of daily living including eating. It further identified Resident #263 was frequently incontinent of bowel and bladder, weighed ninety eight pounds (98 #'s) and had three (3) stage III pressure ulcers. The care plan dated 04/15/08 identified impaired swallow/dysphagia as evidenced by refusal to eat and related to CVA. Interventions included to allow ample time to eat and masticate food properly and monitor weight changes. An integrated (multi-disciplinary) admission assessment dated 04/11/08 at 6:05 PM identified that the resident weighed 98 pounds. As of 4/28/08, the "nutritional risk assessment" portion of the assessment had still not been completed.
Interview and review of the clinical record with the ADNS on 4/28/08 at 11:45 AM, failed to provide evidence that the resident had been assessed by the dietitian. Further review noted that the resident had lost 6 pounds from admission to 4/28/08. The ADNS noted that the facility no longer had a registered dietician (RD) full time during the week, and the RD was only available on weekends.

5. Based on clinical record reviews and interviews for two of ten sampled residents who were admitted in the previous 30 days (Residents #255, #264), the facility failed to complete a comprehensive assessment within 14 days of admission. The findings include:
   a. Resident #264 was admitted on 4/04/08. Review of the clinical record noted that the initial comprehensive assessment failed to be completed by the fourteenth day after admission. Interview with the (interim corporate) MDS coordinator on 5/01/08 at 9:15 AM noted that the facility did not have an MDS coordinator for March and April 2008 and they are now in the process of completing the assessments.
   b. Resident #255 was admitted on 4/03/08. Review of the clinical record noted that the annual assessment reference date (ARD) was 4/08/08 but the assessment was not certified complete via signature until 4/30/08. Interview with the (interim corporate) current MDS coordinator on 5/01/08 at 9:15 AM noted that although the ARD was timely, the certification of accuracy completion signature was not until 4/30/08. The MDS coordinator noted when asked why the assessments were so late, she deferred to the DNS who knew the residents, to sign for the accuracy of the assessment since they did not have an MDS coordinator.

6. Based on clinical record review and interview for four of twenty sampled residents (Residents #23, 172, 164, 40), the facility failed to complete quarterly assessments in a timely manner. The findings include:
   a. On 5/1/08, Resident #172's last assessment noted on the clinical record was dated

1/08/08. Interview and review of the clinical record on 5/01/08 at 9:20 AM with the Corporate MDS Clinical Director failed to identify a subsequent timely quarterly assessment due by 4/8/08. The MDS coordinator noted they were not done for March and April 2008 and the facility is working on them.

b. Resident #164's quarterly assessment had an assessment reference date of 4/4/08. Interview and review of the clinical record with the acting (corporate) MDS coordinator on 5/7/08 at 9 AM noted that the assessment was still incomplete as of 5/7/08.
c. Review of Resident #40's clinical record on 5/01/08 at 9:15 AM with the (interim corporate) MDS coordinator noted that the last quarterly assessment had been conducted 12/21/07. They were unable to provide evidence that a subsequent quarterly assessment had been conducted by 3/21/08.
d. Review of Resident #23's clinical record on 5/8/08 at 10:30 AM with the corporate MDS coordinator, identified that an admission assessment had been conducted on 12/21/07 and that the quarterly assessment (due in March) was never completed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical Records (2)(I).

7. Based on review of clinical records and staff interview for two of 43 sampled residents (Residents #51, #25), the facility failed to ensure that comprehensive care plans were developed to address the resident's needs related to new onset of incontinence, and/or communication. The findings include:

a. Resident #25's diagnoses included peripheral vascular disease and a recent toe amputation. An assessment dated 2/14/08 identified the resident to be without cognitive impairment and totally dependent on staff for activities of daily living including toileting. The resident was noted at that time to be frequently incontinent of urine, but continent of bowel. Nursing progress notes dated 4/8/08 noted that the resident had been readmitted to the facility from the hospital after surgery to amputate a necrotic toe. The readmission nursing assessment dated 4/8/08 identified that the resident was incontinent of bladder as well as bowel upon return from the hospital and that the resident's skin was intact. Nursing progress notes dated 4/16/08 identified that the resident had a new stage two pressure sore on the buttocks. Observation of the resident while receiving morning care on 5/1/08 at 9:35 AM, noted the resident to be incontinent of urine and stool and requiring total assistance from the nurse aide for turning and positioning. An open area (stage 2 pressure sore) was noted on the left buttocks (the dressing had fallen off during care). Interview with the nurse aide at that time, who was providing the care, identified that prior to hospitalization, the resident utilized the toilet with assistance and had occasional episodes of incontinence. She further noted that upon return from the hospital the resident was totally incontinent of bowel and bladder. Review of the clinical record on 4/30/08 at 11:30 AM with the charge nurse, failed to provide evidence that a plan of care had been developed to address the resident's decline in continence and risk for developing pressure sores.

According to the charge nurse, a turn and positioning/incontinent care schedule was not in place until 4/16/08 following the development of the pressure sore, but should have been upon readmission to the facility on 4/8/08.

b. Resident #51's diagnoses included cerebral vascular accident and left hemiplegia. An admission assessment dated 12/12/07 identified the resident to be without cognitive impairment and totally dependent on staff for activities of daily living. Psychiatric progress notes dated 2/7/08 and 3/6/08 identified that the resident's family had reported that the resident was upset because he/she could not communicate and was frustrated because of the inability to be understood by the staff. A care plan dated 3/18/08 identified that the resident was resistive to care, aggressive and physically abusive. Interventions included explaining the adverse effects to the resident of non-compliance with the treatment/plan of care. On 5/2/08 at 8:45 AM while interviewing the charge nurse, it was noted that the resident was often frustrated secondary to a language barrier. Review of the clinical record with the charge nurse at that time identified that a care plan had not been developed that included interventions (i.e. communication board, Spanish speaking interpreters etc.) to assist the resident in communicating her needs to staff.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2).

8. Based on clinical record reviews, observations and interviews for eight sampled residents (Residents #35, 36, 37, 47, 63, 93, 265, 143), the facility failed to administer medications in accordance with physician orders, and/or assess resident's complaints of discomfort, and/or assess a resident following an elopement, and/or assess a resident for signs of dehydration, and/or complete neurological and/or respiratory assessments in accordance with standards of nursing practice or facility policy. The findings include:

   a. Resident #35's diagnoses included acute heart attack. Physician orders dated 4/03/08 directed Nitroglycerin patch 0.2 mg/hr, apply one patch topically every morning and remove every evening; on at 6:00 AM and off at 6:00 PM. Observation of medication administration on 4/28/08 at 8:30 AM noted the night nurse, LPN#5, removing the old nitroglycerin patch (that was ordered to be removed the evening before) and applying the new nitroglycerin patch (which was ordered to be applied at 6 AM).
   Interview with LPN#5 at that time noted that he was the only licensed nurse on the unit and had not expected so many medications for the 6:00 AM administration. Interview on 4/30/08 at approximately 11:30 AM and review of the physician orders with Unit Manager #4 noted that the medication should have been given as scheduled and that the old patch should have been removed at 6:00 PM (the day prior).
   According to Basic Nursing, Mosby, Third Edition, the five guidelines to ensure safe drug administration include the right drug, the right dose, the right client, the right route and the right time.

   b. Resident #143 was admitted to the facility on 11/11/07 with diagnoses that included recent alcohol dependency/abuse and a fall with rib fractures. On 11/12/07 during the

12 AM to 8 AM shift, nurse's notes identify that the resident was restless and wandering the halls. The resident was noted going into other resident's rooms and had to be redirected. At 7:30 AM nurse's notes identify that the resident was noted to be missing from the unit. The supervisor was notified and a missing person policy initiated. Subsequent nursing notes for 11/12/08 indicated that the resident was in the facility, but failed to identify when the resident returned, where he/she was found, and what the condition/assessment of the resident was upon return to the facility.
Interview and review of the clinical record and facility documentation with DNS on 5/1/08 at 11 AM failed to provide evidence that the resident had been assessed upon return to the facility when he/she was found at a local McDonalds and/or that the specifics of the resident's elopement had been investigated and/or documented.
According to the American Nurses' Association Standards of Nursing Practice - The collection of data about the health status of the client / patient is systematic and continuous. The data are accessible, communicated and recorded.

c. Resident #74's diagnoses included dementia. An assessment dated 1/5/08 identified the resident had long and short term memory problems. A care plan dated 1/1/08 identified a potential for falls with approaches that included providing a safe, clutter-free environment.
Nursing notes dated 4/22/08 at 9:40 AM noted that the resident was found on the floor at the foot of the bed with an abrasion on the head. Although neurological assessment were completed on the day and evening shift on 4/22/08, evidence was lacking that the resident's neurological status was assessed the next day, on 4/23/08.
Interview with the ADNS on 5/1/08 at 10:30 AM and review of the clinical record failed to provide evidence that neuro assessments were continued in accordance with facility policy, which directed that neuro signs on the day of the event should be checked every hour for two hours and then every two hours times two. This is followed by neuro signs checked every two hours for two days.

d. Resident #63's diagnoses included syncope, heart block, hypertension and Parkinson's disease. The assessment dated 2/7/08 identified that the resident was cognitively impaired, required limited assistance of staff for activities of daily living and had no behavior or mood indicators. A dehydration risk assessment dated 1/30/08 identified that the resident was at moderate risk for dehydration. The care plan dated originally dated 1/31/08 and updated through 2/19/08 identified the potential for fluid volume deficits/dehydration. Interventions included to record intake and monitor saliva pools and mucous membranes.
The dietitian assessment dated 2/4/08 identified that the resident required between 1575-1890 cc of fluid per day and that the resident had been experiencing diarrhea.
Nurse's notes dated 2/20/08 for the day shift indicated that the resident was agitated and confused and had called the police for help. The resident's psychiatrist was called and ordered Seroquel for agitation. At 9:15 PM, the resident was found lethargic and ashen in color. The blood pressure was 81/56. The attending was notified and the resident transferred to the hospital.

Multiple requests to review intake and output records for the resident resulted in only 5 days provided for review; February 2, 3, 4, 5, and 10, 2008. Only one day was totaled and complete and output was not monitored even though the resident was continent.
The emergency department records dated 2/21/08 identified that the resident received 1 liter of normal saline intravenous fluid bolus over one hour and was placed on fluids at 110 cc per hour after the bolus for dehydration and was returned to the facility.
Review of the clinical record and interview with the Director of Nursing on 5/8/08 at 3:15PM failed to provide evidence that the resident's intake and output had been consistently monitored and/or assessed and/or documented, or that physical assessments for signs of dehydration had been completed/documented as directed by the care plan.
According to the Standard Nursing Practice, second edition, 2003, to assess for risk of dehydration, vital signs and skin turgor must be monitored every four hours. An increased pulse rate, decreased blood pressure and poor skin turgor or dry mucous membranes are signs of dehydration. Intake and output needs to be monitored to determine body fluid status.

e. Resident #37 's diagnoses included chronic obstructive pulmonary disease (COPD), emphysema and bronchitis. An initial assessment dated 03/18/08 identified the resident as having no short and/or long term memory problems and required limited assistance with activities of daily living (ADL). The resident care plan dated 03/14/08 identified a problem with alteration in respiratory status and ineffective breathing related to COPD and bronchitis. Interventions included to administer aerosols/brocho-dilators as ordered and to monitor the effectiveness.
Physician orders dated 4/4/08 directed to administer Ventolin MDI two (2) puffs and Atrovent HFA MDI two (2) puffs by mouth three times per day. Observation on 4/28/08 noted RN #1 administrating medications to Resident #37. Resident #37 stated to RN #1 " I am sick, my stomach hurts - I need to have a bowel movement or throw up". RN #1 continued attempting to administer the medications without acknowledging the resident's complaints. Resident #37 was then noted to say "you're still going to give me those pills?". RN#1 said "yes", administered the medications, and left the resident without conducting any type of assessment.
An interview and review of the clinical record with the ADNS and APRN on 04/29/08 at 12:03 PM failed to provide evidence that an assessment had been conducted and/or documented. The ADNS further indicated that it was the facility policy to document complete assessments of resident's complaints of discomfort.
According to the Illustrated Manual of Nursing Practice, Third Edition, 2002, the patient's health status is compared to the norm in order to determine if there is a deviation from the norm and the degree and direction of the deviation.
According to the American Nurses' Association Standards of Nursing Practice - The collection of data about the health status of the client / patient is systematic and continuous. The data are accessible, communicated and recorded.

f. Resident #47's diagnoses included severe mental retardation. On 4/19/08 at 11 PM the resident was noted to be congested and coughing. The resident's pulse oximetry was

90%(Normal = greater then 92%). Suctioning was initiated with tan, rust-colored secretions obtained. Oxygen was initiated and an X-ray was ordered by the physician which identified a right basilar atelectasis. On 4/20/08 at 7 AM, the resident was identified as congested and coughing with loose secretions.
Review of the clinical record and interview with the DNS on 5/1/08 at 10:30 AM identified that a follow-up respiratory assessment was not completed until 4/20/08 at 11:15 PM. The DNS identified that a respiratory assessment should have been completed on each shift or more frequently as required. Interview further identified that the facility was short-staffed and the resident's floor/unit lacked continuous licensed nurse coverage on the day shift 4/20/08. She noted that the facility was unable to find a replacement nurse from either the facility staff or agency staff.
According to the Lippincott Manual of Nursing Practice, eighth edition, 2006, when caring for a patient at risk for respiratory compromise, be aware of the status of the patient when assuming care so comparison can be made with subsequent assessments. Perform a thorough systematic assessment including mental status, vital signs, respiratory status, and cardiovascular status. Document the patient's condition to provide a record for continuity of care. Evaluate for signs of hypoxia when anxiety, restlessness, confusion, or aggression of new onset are noted.

g. Resident #36's diagnoses included dementia. On 4/20/08 at 6AM the resident was noted to have an audible expiratory wheeze. The residents room-air oxygen saturation was 92%.(Normal = above 92%). A nebulizer treatment was administered as ordered with good effect and emotional support was provided.
Review of the clinical record and interview with the Director of Nurses (DNS) on 5/1/08 at 10:30 AM failed to identify any follow-up respiratory assessments recorded/completed for the resident until 11:15 PM. The DNS identified that a respiratory assessment should have been completed on each shift or more frequently as required. She identified that the facility was short-staffed, there was not a continuous licensed staff member on the unit during the day shift between 8 AM - 4 PM, and that the facility was unable to find a replacement nurse from either the facility staff or agency staff.
According to the Lippincott Manual of Nursing Practice, eighth edition, 2006, when caring for a patient at risk for respiratory compromise, be aware of the status of the patient when assuming care so comparison can be made with subsequent assessments. Perform a thorough systematic assessment including mental status, vital signs, respiratory status, and cardiovascular status. Document the patient's condition to provide a record for continuity of care. Evaluate for signs of hypoxia when anxiety, restlessness, confusion, or aggression of new onset are noted.

h. Resident #93 diagnoses include implanted defibrillator, angioplasty with stent insertion, coronary artery disease, atrial fibrillation, chest pain, and congestive heart failure with an ejection fraction of 25%. An assessment dated 4/8/08 identified the resident to be without cognitive impairment and requiring limited assistance with activities of daily living. A care plan dated 5/8/08 identified an alteration in cardiac function as evidenced

by chest pain and anxiety. Interventions included minimizing agitation or situations which cause anxiety. The care plan directed that nitroglycerin be administered for chest pain.

Interview with Resident #93 on 4/30/08 at 11:45 AM identified that at approximately 9:45 AM on 4/20/08, he/she was experiencing chest pain and needed the nitroglycerin to relieve it. He/she reported that a nurse aide came to the room and said she would get the supervisor. According to the resident, there was no nurse available on the unit and he had to wait forty five minutes before a nurse came to his room and administered the medication/Nitroglycerin.

In a written statement from Supervisor #1, she noted that due to the failure to schedule an adequate number of licensed nurses for the weekend of 4/19, 20/08, and callouts and no shows from the agencies that were booked, the facility was without a nurse on the fourth floor during the 8-4pm shift on 4/20/08. She had attempted every nurse on staff and agencies to fill the vacancies without success. She called the DNS several times who told her she would be there later. The ADNS was called and did not return the phone calls.

The supervisor explained that she had expected the DNS to arrive at the facility around 11AM, following an early morning conversation that she had with the DNS. She was in the office resting when she was called to the 4th floor sometime after 10 AM by a nurse aide who reported that Resident #93 was having chest pain. Supervisor #1 noted that she arrived on the 4th floor at that time and administered the nitroglycerin to R#93 three times before the chest pain subsided. She noted that she stayed with the resident for a while and held his/her hand and then left the unit. She noted that when the DNS failed to show up to relieve her at approximately 11:45 AM, she returned to the unit and gave the resident the medications that had been scheduled/ordered for 9-9:30 AM including:

Plavix 75 mg at 9:30 AM
Betapace 160 mg at 9:30 AM
Aldactone 12.5 mg at 9:30 AM
Ranexa 500 mg (twice a day) at 9 AM
Lasix 40 mg at 9:30 AM
Imdur 90 mg at 9:30 AM
Zestril 30 mg at 9:30 AM

Interview with the medical director on 5/15/08 and review of the delayed response to the administration of nitroglycerin on 4/2/08 identified that he would think that the delay in receiving medications would have caused increased anxiety related to the nurse not being on the floor.

Further review of the clinical record and 24 hour reports failed to provide evidence that the 3 doses of nitroglycerin administered to the resident and/or an assessment of the resident's chest pain, had been documented in the medication administration record, nursing notes, or 24 hour reports.

According to the American Nurses' Association Standards of Nursing Practice - The collection of data about the health status of the client/patient is systematic and

continuous. The data are accessible, communicated and recorded.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(B).

9. Based on clinical record reviews, observations and interviews for one of 4 residents observed receiving incontinent care (Resident #40), the facility failed to implement skin breakdown prevention measures in accordance with the plan of care.
    a. Resident #40's diagnoses included UTI, dehydration, status post right hip fracture, and altered mental status. A quarterly assessment dated 12/21/07 identified that the resident was totally dependent on staff assistance for toileting and personal hygiene and was incontinent of bowel and bladder. The care plan dated 1/03/08 (3/20/08 and 4/06/08) identified a potential for alteration in skin integrity. Interventions included incontinent care and barrier cream. Observations on 4/28/08 at 10:10 AM noted the Nurse Aide (NA) provided morning care to the resident. After washing the resident, the NA failed to apply barrier cream as indicated. Interview with the NA on 4/28/08 at 10:25 AM noted that she usually applies barrier cream and following surveyor inquiry applied the cream.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D) and/or (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

10. Based on clinical record reviews, and interviews for 35 sampled residents (Residents #2, 3, 9, 16, 23, 35, 36, 37, 40, 41, 46, 47, 51, 53, 56, 58, 61, 66, 70, 80, 83, 93, 95, 110, 116, 130, 140, 149, 151, 164, 169, 172, 179, 255, 264), the facility failed to ensure that residents received the medications and/or treatments ordered by their physicians, and/or the facility neglected to ensure that adequate licensed nurses were on duty at all times to ensure appropriate treatment and services to the residents. The findings include:
    a. Resident #93 diagnoses include implanted defibrillator, angioplasty with stent insertion, coronary artery disease, atrial fibrillation, chest pain, and congestive heart failure with an ejection fraction of 25%. An assessment dated 4/8/08 identified the resident to be without cognitive impairment and requiring limited assistance with activities of daily living. A care plan dated 5/8/08 identified an alteration in cardiac function as evidenced by chest pain and anxiety. Interventions included minimizing agitation or situations which cause anxiety. The care plan directed that nitroglycerin be administered for chest pain.
    Interview with Resident #93 on 4/30/08 at 11:45 AM identified that at approximately 9:45 AM on 4/20/08, he/she was experiencing chest pain and needed the nitroglycerin to relieve it. He/she reported that a nurse aide came to the room and said she would get the supervisor. According to the resident, there was no nurse available on the unit and he had to wait forty five minutes before a nurse came to his room and administered the medication/Nitroglycerin.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

In a written statement from Supervisor #1, she noted that due to the failure to schedule an adequate number of licensed nurses for the weekend of 4/19, 20/08, and callouts and no shows from the agencies that were booked, the facility was without a nurse on the fourth floor during the 8-4pm shift on 4/20/08. She had attempted every nurse on staff and agencies to fill the vacancies without success. She called the DNS several times who told her she would be there later. The ADNS was called and did not return the phone calls.

The supervisor explained that she had expected the DNS to arrive at the facility around 11AM, following an early morning conversation that she had with the DNS. She was in the office resting when she was called to the 4th floor sometime after 10 AM by a nurse aide who reported that Resident #93 was having chest pain. Supervisor #1 noted that she arrived on the 4th floor at that time and administered the nitroglycerin to R#93 three times before the chest pain subsided. She noted that she stayed with the resident for a while and held his/her hand and then left the unit. She noted that when the DNS failed to show up to relieve her at approximately 11:45 AM, she returned to the unit and gave the resident the medications that had been scheduled/ordered for 9-9:30 AM including:

Plavix 75 mg at 9:30 AM
Betapace 160 mg at 9:30 AM
Aldactone 12.5 mg at 9:30 AM
Ranexa 500 mg (twice a day) at 9 AM
Lasix 40 mg at 9:30 AM
Imdur 90 mg at 9:30 AM
Zestril 30 mg at 9:30 AM

Interview with the DNS on 4/30/08 at 9:30 AM noted that although she was aware of the insufficient licensed staff, and the fact that the supervisor had been on duty for the 3rd straight shift, she was not able to come to the facility until the afternoon. She stated that the ADNS was unable to come into the facility because she had no car and no one to watch her children.

Interview with the medical director on 5/15/08 and review of the delayed response to the administration of nitroglycerin on 4/2/08 identified that he would think that the delay in receiving medications would have caused increased anxiety related to the nurse not being on the floor.

b. Resident #35's diagnoses included acute myocardial infarction, rhabdomyolysis, congestive heart failure, and arthritis. Physician orders dated 4/3/08 directed the administration of aspirin 81 mg daily (10 AM), Depakote 125 mg twice a day (10 AM), Lasix 40 mg daily (10 AM), Potassium 20 meq daily (10 AM), and Metoprolol 12.5 mg twice a day (10 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician.

c. Resident #140's diagnoses included cardiac arrhythmias and hypertension. Physician orders dated 4/4/08 directed the administration of Cardizem CD 120 mg daily (9 AM), Folic Acid 1 mg daily (9 AM), and Toprol XL 200 mg daily (9:30 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted

medications/doses as ordered by the physician.

d. Resident #175's diagnoses included seizure disorder, atrial fibrillation, diabetes and dementia. Physician orders dated 3/3/08 directed the administration of Dilantin 300 mg daily (9 AM), Provigil 100 mg daily (9 AM), Bactrim SS daily (9 AM), Tylenol 1000 mg twice a day (9 AM), and Norvasc 10 mg daily (9:30 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician.

e. Resident #61's diagnoses included cirrhosis, diabetes, stroke and depression. Physician orders dated 3/7/08 directed the administration of Keppra 500 mg twice a day (9 AM), Folic acid 1 mg daily (9:30 AM), Zestril 40 mg daily (9:30 AM), Plavix 75 mg daily (9:30 AM), and Zoloft 100 mg daily (9:30 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician.

f. Resident #46's diagnoses included stroke and congestive heart failure. Physician orders dated 3/18/08 directed the administration of Zestril 20 mg daily (10 AM), and Coreg 12.5 mg two tablets twice a day (10 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician.

g. Resident #41's diagnoses included Alzheimer's disease, Parkinson's disease, and depression. Physician orders dated 3/12/08 directed the administration of Zoloft 50 mg daily (9 AM) and Sinemet 25/100 two tablets twice a day (9 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician.

h. Resident #53's diagnoses included Alzheimer's disease, an transient ischemic attacks. Physician orders dated 3/5/08 directed the administration of Namenda 10 mg twice a day (10 AM), and Plavix 75 mg daily (10 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician.

i. Resident #36's diagnoses included diabetes, dementia, and hypertension. Physician orders dated 4/2/08 directed the administration of Amitiza 24 mcg twice a day (10 AM), Toprol XL 100 mg daily (10 AM), and regular insulin via a sliding scale based on blood sugar checks to be done 4 times a day (11:30 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician.

j. Resident #172's diagnoses included depression, and glaucoma. Physician orders dated 4/3/08 directed the administration of Alphagan eye drops twice a day (9 AM), Timolol eye drops twice a day (9 AM), and Metoprolol 25 mg 1/2 tabs twice a day (9 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician.

k. Resident #51's diagnoses included depression, stroke, atrial fibrillation, hypertension, and constipation. Physician order dated 4/3/08 directed the administration of Dulcolax 5 mg tablet daily (1 PM), Digoxin 0.125 mg daily (1 PM), Cardizem CD 240 mg daily (1

PM), Lisinopril 20 mg daily (1 PM), Plavix 75 mg daily (1 PM), Lasix 20 mg daily (1 PM), and Amitiza 24 mcg daily (1 PM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician.

l. Resident #58's diagnoses included ulcerative colitis, hypertension and cardiac arrhythmia. Physician orders dated 2/26/08 directed the administration of Diovan 80 mg daily (10 AM), Lexapro 10 mg daily (10 AM), Vitamin B12 1,000 mcg daily (10 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician.

m. Resident #149's diagnoses included diabetes and Alzheimer's disease. Physician orders dated 4/5/08 directed the administration of Risperdal 0.25 mg twice a day (9 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician.

n. Resident #70's diagnoses included stroke, dementia, diabetes, and coronary artery disease. Physician orders dated 3/13/08 directed the administration of Atenolol 50 mg three times a day (2 PM), Quinapril 40 mg daily (9 AM), and hydrochlorothiazide 12.5 mg daily (9 AM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician.

o. Resident #116's diagnoses included dementia with psychosis, Alzheimer's disease, and osteoporosis. Physician orders dated 4/12/08 directed the administration of Baclofen 10 mg every eight hours (2 PM), Tylenol 1000 mg every 8 hours (2 PM), and Benadryl 12.5 mg every twelve hours (9 AM for a rash). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive the above noted medications/doses as ordered by the physician.

p. Resident #264's diagnoses included hypertension, stroke, dysphagia and gastrostomy tube placement. Physician orders dated 4/8/08 directed the administration of Aspirin 325 mg daily (9AM), Zocor 20 mg daily (9 AM), and Prevacid 20 mg daily (9 AM). On 4/20/08 during the 8 AM-4PM shift, the resident did not receive the above noted medication doses.

q. Resident #179's diagnoses included aspiration pneumonia. Physician orders dated 4/4/08 directed the administration of Prostat 30 ml twice a day (9AM), Trazodone 25 mg twice a day (10 AM), Labetalol HCL 100 mg daily (9 AM), Lexapro 10 mg daily (9AM), Patanol eye drops twice a day (9 AM), and on 4/11/08, orders directed Nystatin swab to mouth and tongue four times a day (9 AM and 1 PM). On 4/20/08 during the 8 AM to 4 PM shift, the resident did not receive any of the above noted medication doses.

r. Resident #255's diagnoses included recent laminectomy. Physician orders dated 4/17/08 directed Lotrimin twice a day to the peri area and fold on the back. On 4/20/08, the resident did not receive the treatment as ordered.

s. Resident #169's diagnoses included dementia with psychosis, diabetes and seizures. Physician orders dated 3/12/08 directed the administration, in part, of Ibuprofen 600 mg three times a day (12 noon), aspirin 81 mg daily (10 AM), Sinemet 10/100 twice a day (10 AM), Lasix 40 mg daily (10 AM), Lexapro 10 mg daily (10 AM), Potassium 10 meq daily (10AM), and Mysoline 50 mg daily at 10 AM. On 4/20/08 during the 8 AM to 4

PM shift, the resident failed to receive the above noted doses of medications as ordered by the attending physician.

t. Resident #164's diagnoses included stage IV pressure sore of the right buttock, dementia, and Parkinson's disease.
    i. Physician orders dated 3/14/08 directed the administration, in part, of Sinemet 25/100 twice a day (10 AM), Namenda 10 mg twice a day (10 AM), Plavix 75 mg every day (10 AM), Zocor 20 mg daily (10 AM), Oxycodone 5 mg, 1/2 tab twice a day (9AM), and Tylenol 1000 mg every 8 hours (2 PM). On 4/20/08 during the 8 AM-4PM shift, the resident did not receive the above medications as ordered by the attending physician.
    ii. Resident #164's physician orders dated 3/14/08 directed to float the left heel at all times, and to check positioning and skin condition every shift. Physician orders dated 4/9/08 directed to irrigate the right buttock stage IV pressure sore with normal saline and to pack with saline moistened gauze twice a day for 14 days. On 4/20/08 during the 8 AM-4PM shift, the resident failed to receive the treatments above as ordered by the physician.

u. Resident #151's diagnoses included Alzheimer's disease grand mal seizures, and failure to thrive. Physician orders dated 4/19/08 directed the administration of Pronutra one bottle twice a day (10 AM) and Depakote 250 mg every 8 hours (2 PM). On 4/20/08 during the 8 AM - 4 PM shift, the resident did not receive the above noted medication and/or supplement.

v. Resident #130's diagnoses included anxiety, Alzheimer's disease and chronic obstructive pulmonary disease. Physician orders dated 4/3/08 directed the administration of Xanax 0.25 mg every morning at 9 AM, Lexapro 10 mg, every morning at 9 AM, Vitamin C 500 mg every morning at 9 AM, Namenda 10 mg every morning at 10 AM, and Seroquel 50 mg every morning at 10 AM. On 4/20/08 during the 8 AM - 4 PM shift, the resident did not receive the medications listed above as ordered by the physician.

w. Resident #110's diagnoses included stroke, and depression. Physician orders dated 1/25/08 (please also refer to failure of physician to visit timely, F387) directed the administration of Aspirin 81 mg daily at 9 AM, Zoloft 50 mg daily at 9 AM, and barrier topically to both heels twice a day including once on the 8 AM to 4 PM shift. On 4/20/08 the resident failed to receive the medications and treatment as ordered by the attending physician.

x. Resident #95's diagnoses included stage four pressure sore, seizure disorder, and dementia.
    i. Resident #95's physician orders dated 4/3/08 directed the administration of Dilantin 100mg every 12 hours (9AM), Pronutra mixed with 180 cc of water via gastrostomy tube (G-tube) twice a day (9 AM), 200 cc of water flushes via G-tube four times a day (at 12 noon), and bolus tube feedings with Jevity four times a day (10 AM and 2 PM). On 4/20/08 the resident failed to receive the above medications and/or nutrition as ordered by the physician.
    ii. Resident #95's physician orders dated 4/17/08 directed a daily treatment to

the stage IV pressure sore on the left hip of irrigation with normal saline followed by packing the wound with Iodophor gauze. Physician orders dated 4/3/08 directed cleansing of the G-tube site twice a day followed by the application of Bactroban. On 4/20/08 during the 8 AM - 4 PM shift, the resident did not receive the treatments as prescribed by the attending physician. On 4/24/08, the APRN assessed the wound and changed the treatment order to Dakin's solution packing twice a day although the measurement of the wound had not changed.

y. Resident #83's diagnoses included diabetes, hypertension, and aspiration pneumonia. Physician orders dated 4/18/08 directed the resident receive Duoneb four times a day (9 AM and 1 PM) for 7 days. Physician orders dated 4/17/08 directed that the resident receive Reglan 5 mg three times a day with meals (11AM), Starlix 60 mg three times a day before meals (11 AM), Cosopt eye drops twice a day (10 AM), Cymbalta 60 mg daily (10 AM), Lasix 20 mg daily (10 AM), Metoprolol 25 mg twice a day (10 AM), Namenda 5 mg twice a day (10 AM). On 4/20/08 during the 8 AM-4 PM shift, the resident did not receive the above medication doses as ordered by the attending physician.

z. Resident #82's diagnoses included stroke, dysphagia, pressure sores, and pneumonia. Physician orders dated 4/3/08 directed treatments including incentive spirometry three times a day at 9 AM and 1 PM, and to assess the resident's oxygen saturation every shift and maintain it over 90%. On 4/20/08 during the 8 AM-4 PM shift the resident did not receive the above noted assessment and/or treatment.

aa. Resident #66's diagnoses included pneumonia, dysphagia, diabetes, hypertension, and colostomy. Physician orders dated 3/18/08 directed staff to provide colostomy care every shift and to apply "No Sting Barrier" to the area surrounding the ostomy site every shift. On 4/20/08 during the 8 AM-4 PM shift, the resident failed to receive the treatments as ordered by the physician.

ab. Resident #56's diagnoses included dementia, stroke,diabetes, congestive heart failure, and depression. Physician orders dated 4/3/08 directed the administration of Lasix 40 mg daily (10 AM), Lisinopril 20 mg daily (10 AM), Plavix 75 mg daily (10 AM), and Celexa 20 mg once a day (10 AM), On 4/20/08 during the 8 AM-4PM shift, the resident did not receive the above noted medications as ordered by the physician.

ac. Resident #47's diagnoses included stroke, Parkinson's disease, and severe mental retardation. Physician orders dated 4/3/08 directed the administration of Sinemet 25/100 four times a day (9 AM and 1 PM), Comtan 200 mg four times a day (9 AM and 1 PM), Requip 2 mg three times a day (9 AM and 1 PM), Aspirin 325 mg daily (9 AM), Depakote 125 mg every 12 hours (10 AM), and Ativan 0.75 mg daily (10 AM). On 4/20/08 during the 8 AM-4PM shift, the resident did not receive the above noted medications.

ad. Resident #40's diagnoses included dehydration, and hip fracture. Physician orders dated 2/26/08 directed that the resident receive Reglan 5 mg twice a day before breakfast and lunch (7:30 AM and 11:30 AM), and Quinapril 20 mg daily (10 AM). On 4/20/08

during the 8 AM - 4 PM shift, the resident did not receive the above medications as ordered by the physician.

ae. Resident #16's diagnoses included hypertension, osteoarthritis, and constipation. Physician orders dated 3/26/08 directed the administration of Tylenol 1,000mg three times a day (9AM and 1 PM), Colace 100 mg twice a day (9 AM), Metoprolol 25 mg, 1/2 a tablet twice a day (10 AM), and a Lidoderm patch to the right knee apply at 9 AM. On 4/20/08 during the 8 AM - 4 PM shift, the resident did not receive the above noted medications.

af. Resident #9's diagnoses included dementia, stroke, hypoxia with respiratory failure, and seizures. Physician orders dated 4/3/08 directed the administration of Dilantin 100 mg twice a day (9 AM), Prostat 30 ml daily (9 AM), and Colace 100 mg three times a day (9 AM and 1 PM). On 4/20/08 during the 8 AM -4 PM shift, the resident did not receive the above noted medications as ordered by the physician.

ag. Resident #3's diagnoses included myxedema, hypertension, and dementia. Physician orders dated 4/3/08 directed the administration of, in part, Lasix 40 mg daily at 9 AM, Namenda 5 mg twice a day including 9 AM, and Risperdal 0.25 mg twice a day including 9 AM. On 4/20/08 during the 8 AM-4 PM shift, the resident failed to receive the medications above as directed by the physician.

ah. Resident #2's diagnoses included Parkinson's disease and depression. Physician orders dated January 10, 2008 directed the administration of Sinemet 25/100 four times a day at 9 AM and 1 PM, Zoloft 100 mg at 9 AM, Flovent 110 mcg inhaler at 10 AM (every 12 hours), Os-Ca; 250+D two tablets at 9AM and 1 PM (four times a day), and aspirin 81 mg daily at 9 AM. On 4/20/08, Resident #2 did not receive the above directed medications as ordered on the 8 AM-4 PM shift.

Interviews with residents, families, and facility staff noted that on 4/20/08, the 4th floor did not have a licensed nurse on duty at all times.

Investigation and interview with the supervisor on 4/30/08 at 12 PM noted that due to call outs and the inability to replace any nurses, she had no choice but to stay at the facility for a 3rd shift in a row. She indicated that she was so tired that she had to put her head down for a while in the office and had difficulty reading the kardexes to administer medications (a clerical staff member came in and assisted the supervisor with reading the kardexes and medication labels). The supervisor noted that the DNS informed her that she would be in to relieve her at about 11 AM. She further indicated that she attempted to give the respiratory, cardiac and diabetic medications, but was unable to complete a medication pass on all the residents and did not do any of the prescribed treatments for the shift. The supervisor also noted that each of the other two floors had an agency LPN on duty and therefore she was responsible for overseeing and orienting them to the facility.

Interviews with the DNS on 4/20/08 at 11:35 AM noted that upon arrival at the facility on 4/20/08 around 2 PM, she did not call any of the physicians and/or the medical director for direction on the omitted medications, did not administer any of the once a day medications or 2 PM medications, and did not do any of the treatments.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

ai. Resident #23's diagnoses included diabetes and congestive heart failure. Physician orders dated 4/04/08 directed the administration of a Flovent inhaler two puffs twice a day, at 10:00 a.m and 6 p.m., Robitussin DM syrup 10 ml. twice a day at 10:00 a.m. and 5 p.m., Norvasc 5 mg daily at 10:30 a.m., Celebrex 100mg daily at 10:30 a.m., Lisinopril 20mg daily at 10:30 a.m., potassium chloride sa 20 meq. daily at 10:30 a.m., Coreg 12.5 mg. twice a day at 10:00 a.m. and 9 p.m., and Lasix 60 mg daily at 10:30 a.m. Observation of medication administration on 4/30/08 at 12:30 p.m. identified that the medication nurse was still administering the morning (10 AM and 10:30 AM) medications. Interview with the medication nurse at that time noted that there was to be a second nurse on the floor with her, but they were working short. The nurse identified that the medication was late and administered at the wrong time.
Although a finding of immediate jeopardy was identified, the facility provided an immediate action plan to correct the jeopardy.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A) and/or (m) Nursing Staff (2)(B).

11. Based on review of clinical records, observations, and staff interviews for four of four residents in the survey sample with a pressure sore (Residents #25, 164, 252, 259), the facility failed to assess the resident's for risk of developing a pressure sore and/or failed to develop and implement interventions to prevent pressure sores from developing, and/or aide in healing, and/or the facility failed to assess the resident's wounds and document the findings in a manner consistent with assessment standards, and/or failed to provide the wound care ordered by the resident's physician. The findings include:

a. Resident #25's diagnoses included peripheral vascular disease and a recent toe amputation. An assessment dated 2/14/08 identified the resident to be without cognitive impairment and totally dependent on staff for activities of daily living including toileting. The resident was noted at that time to be frequently incontinent of urine but continent of bowel.
Nursing progress notes dated 4/8/08 noted that the resident had been readmitted to the facility from the hospital secondary to amputation of a necrotic toe. The readmission nursing assessment dated 4/8/08 identified that the resident was incontinent of bladder as well as bowel upon return from the hospital and that the resident's skin was intact.
Nursing progress notes dated 4/16/08 identified that the resident had a new stage two pressure sore on the buttocks.
Observation of the resident while receiving morning care on 5/1/08 at 9:35 AM, noted the resident had been incontinent of urine and stool and required total assistance from the nurse aide for turning and repositioning. A pressure sore was visible on the buttocks (the dressing had fallen off during care). Interview with the nurse aide at that time identified that prior to hospitalization, the resident utilized the toilet with occasional episodes of incontinence. She noted that upon return from the hospital, the resident was totally incontinent of bowel and bladder.

Review of the clinical record on 4/30/08 at 11:30 AM with the charge nurse, identified that the facility failed to assess the resident's risk for skin breakdown after returning from the hospital on 4/8/08. Review of the clinical record with the charge nurse noted a failure to develop a care plan that included incontinent care and a turning and positioning schedule. According to the charge nurse, a turn and positioning schedule was not in place until 4/16/08, when the resident had already developed a pressure sore. The record lacked evidence that the resident had been repositioned at least every two hours prior to development of the pressure sore.

b. Resident #164's diagnoses included stage IV pressure sore of the right buttock, dementia, and Parkinson's disease. Physician orders dated 3/14/08 directed to float the left heel at all times, and to check positioning and skin condition every shift. Physician orders dated 4/9/08 directed to irrigate the right buttock stage IV pressure sore with normal saline and to pack with saline moistened gauze twice a day for 14 days.
On 4/20/08 during the 8 AM-4PM shift, the resident failed to receive the treatments above as ordered by the physician. Treatments failed to be signed off as completed on 4/24, 4-12 shift, 4/27 4-12, 4/29 8-4, and on both shifts on 4/30/08.
Review of the wound assessment documentation identified that the wound had declined from 0.8 by 0.8 by 0.5 cm on 4/17/08 to 0.8 by 1.0 by 0.6 cm on 4/24/08. Treatment orders were changed to Dakin's solution on 4/24/08.
Interview with RN#2 on 5/7/08 8:30 AM noted that the agency nurses had voiced difficulties with being able to complete assignments including treatments.

c. Resident #259's diagnoses included acute respiratory distress, pneumonia and chronic obstructive pulmonary disease (COPD). An initial assessment dated 03/21/08 identified the resident had short term memory problems, required limited assistance with bed mobility, extensive assistance with activities of daily living (ADL), was occasionally incontinent of bowel and bladder, and had three stage IV pressure ulcers.
A nursing admission assessment dated 03/14/08 identified that the resident was admitted at 2:40 PM with three stage IV pressure areas. The areas located on left buttock, measured 3.0 cm x 2.8 cm, the sacrum measured 0.4 cm x 0.4 cm and the right buttock measured 3.0 cm x 3.5 cm. The skin breakdown assessment dated 3/14/08 identified the resident was at high risk, requiring "immediate implementation of appropriate preventative measures."
The resident care plan (RCP) dated 03/14/08 identified a problem with skin impairment. Interventions included to turn and position every two (2) hours, and provide incontinent care every two (2) hours and as needed.
The clinical record lacked skin assessments from 3/17/08 to 4/2/08. Facility skin assessment documentation dated 4/2/08 noted that the sacrum area had combined with the right buttock wound and now measured 3.0 cm x 3.0 cm x 2.2 cm in depth with slough present. Review of RCP "evaluation" dated 04/02/08 noted "sacral extending to right buttock stage IV". It further identified that "patient is on a turn and positioning schedule" and that a "air mattress was ordered per recommendations". A receipt dated 04/03/08 was noted in the record identifying the delivery date of a low air loss bed.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Review of facility "skin care & wound program" policy and procedure with the corporate nurse, RN #2, identified that it was facility policy to place patients who are admitted with stage III and/or stage IV pressure ulcers on a low air loss bed upon admission to the facility. An interview and review of Resident #259's clinical record with the facility wound nurse, RN#3, on 05/01/08 at 10:04 AM identified that the resident's pressure areas had declined when the sacrum area combined with the right buttock. Further review with RN#3 failed to provide evidence that the resident's pressure ulcers were assessed and/or measured from 03/17/08 through 04/02/08 (16 days). RN #3 indicated that although it was her practice to place patients admitted with stage III and/or IV pressure ulcers on low air loss beds, she was on vacation at that time and it was the responsibility of other facility staff to do the assessments and/or implement appropriate preventative measures while she was gone.

d. Resident # 252 was admitted to facility on 03/11/08 with diagnoses that included traumatic brain injury (TBI). An initial assessment dated 03/18/08 identified that the resident was moderately cognitively impaired, required extensive assistance with activities of daily living (ADL) including bed mobility, and did not have any pressure ulcers. A re-admission integrated (interdisciplinary) assessment dated 4/13/08 identified the presence of pressure ulcers, but failed to identify location, size and/or characteristics of the pressure sores.

The care plan (RCP) dated 03/11/08 identified a potential for skin impairment secondary to impaired mobility and diabetes. The care plan did not identify the presence of any pressure sores.

Review of wound tracking/assessment documentation dated 4/13/08 identified both the right and left buttock was "excoriated with areas of slough". A nurse practitioner note dated 04/17/08 identified a 0.5 cm x 0.8 cm x 0.1cm stage II located on left buttock and a right buttock stage II area that measured 1.8 cm x 1.0 cm x 0.1cm. On 04/23/08 a new open area was identified on the scrotum that measured 1.5 cm x 0.3 cm.

Observation of resident on 5/4/08 from 6:37 AM through 9:25 AM (2 hours 48 minutes) noted that the resident remained positioned on the back without the benefit of repositioning or an incontinence check.

During an interview with NA#1 on 5/6/08 at 12:05 PM, identified that her shift began at 8:00 AM, that it was a very busy day and it was difficult to take care of everyone.

An interview and clinical record review 5/6/08 at 1:12 PM with the wound nurse, RN #3 and the ADNS, identified that residents at risk for breakdown should be repositioned every two (2) hours. Further review identified that the right buttock increased in size on 4/17/08, and that the RCP had not been reviewed/revised to reflect the presence of the pressure sores with individualized interventions to promote healing and/or prevent new pressure ulcers from developing.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (o) Medical records (2)(H).

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

12. Based on review of clinical records, observations and staff interviews for three of nine sampled residents who were incontinent of bladder (Residents #25, 40, 61) the facility failed to assess the resident for a decline in bladder function and/or provide care in a manner that prevents urinary tract infections, and/or failed to attempt to improve/restore bladder function when the resident was assessed to be a candidate for retraining. The findings include:

    a. Resident #61 was admitted on 11/11/07 with diagnoses that included hypotension, and cirrhosis of the liver. The initial assessment dated 11/23/07 identified that the resident had some memory problems, required extensive assistance of one to two staff for transfer and toilet use, and was frequently incontinent of bladder.
    Flow sheets for November 2007 were not available for review. The care plans dated 11/11, 12/07 identified problems related to urinary incontinence and a potential for knowledge deficit regarding discharge home. Interventions included to evaluate for bowel and bladder continence and place on an appropriate program, to follow protocol for appropriate program and document progress or lack of and anticipate tentative discharge date.
    Facility policy for Urinary Continence and Incontinence- Assessment and Management directed that the physician and staff will provide appropriate services and treatment to help residents to restore or improve bladder function and prevent urinary tract infections to the extent possible. Policy Interpretation and Implementation directed that as part of the initial and ongoing assessments, the nursing staff and physician will screen for information related to urinary incontinence.
    A care plan dated 1/30/08 identified a UTI treated with antibiotic therapy. Quarterly assessment dated 2/08/08 identified some memory improvement and decline in bladder continence to incontinent all or most of the time. Review of the flow sheets from 12/1/07 through 12/15/07, and from January 2008 through February 8, 2008 noted that the resident was incontinent of bladder.
    Interview on 5/01/08 at 2:55 PM with he DNS noted that although the clinical record identified a continency assessment completed on 11/11/07 resulting in the resident being identified as a "17" or having a high potential for retraining, documentation that any attempts at bladder restoration/retraining were lacking. The DNS noted that the facility does not have a policy/program for implementing restoration of bladder function at this time.

    b. Resident #40's diagnoses included UTI, dehydration, status post right hip fracture, and altered mental status. A quarterly assessment dated 12/21/07 identified that the resident was totally dependent on staff assistance for toileting and personal hygiene and was incontinent of bowel and bladder. The care plan dated 1/03/08 (with reviews on 3/20/08 and 4/06/08) identified the potential for alteration in skin integrity. Interventions included incontinent care and barrier cream as indicated.
    Laboratory reports dated 9/24/07 and 10/11/07 identified urinary tract infections of Klebsiella pneumoniae and gram negative bacilli.
    Observations on 4/28/08 at 10:10 AM noted the Nurse Aide (NA) providing morning care to the resident. The resident was seated in the bath room of the common shower

room. The NA was observed to place the washcloths used to provide perineal care in the bathroom sink where she ran the water and applied soap to the wash cloths. The NA used the clothes that had been sitting in the common use sink to wash the resident including the provision of perineal care.
Interview with the DNS on 5/01/08 at 10:40 AM noted that a basin of water should have been used and the wash-cloths should not have been put directly into the sink. Facility policy directs for a basin of water to be used for perineal care.

c. Resident #25's diagnosis of peripheral vascular disease and a recent toe amputation. An assessment dated 2/14/08 identified the resident was without cognitive impairment, totally dependent on staff for activities of daily living including toileting, and was frequently incontinent of urine but continent of bowel.
Nursing progress notes dated 4/8/08 noted that the resident had been readmitted to the facility from the hospital secondary to amputation of a necrotic toe. The readmission nursing assessment dated 4/8/08 identified that the resident was incontinent of bladder as well as bowel and the skin was intact. Nursing progress notes dated 4/16/08 identified that the resident had a new stage two pressure sore on the buttocks.
Observation of the resident while receiving morning care on 5/1/08 at 9:35 AM, noted the resident had been incontinent of urine and stool.
Interview with the nurses aide at that time identified that prior to hospitalization, the resident utilized the toilet with occasional episodes of incontinence. She further noted that upon return from the hospital the resident was totally incontinent of bowel and bladder.
Review of the clinical record on 4/30/08 at 11:30 a.m. with the charge nurse, failed to provide evidence that the resident's continency and/or potential for restoration of continency, had been assessed upon return from the hospital and/or when the decline in functioning was noted. According to the charge nurse at that time, residents should be assessed upon readmission and/or when the resident's bowel and bladder function declines, a restoration program should be initiated.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(C).

13. Based on clinical record reviews, observations, interviews, and review of facility documentation for three of three sampled residents with incidents/accidents (Residents #265, #172, #143), the facility failed to assess the resident's risk for elopement and/or supervise the resident when restless, and/or failed to assess the origin of injuries of unknown origin and develop/implement interventions to prevent further injuries, and/or failed to transfer/handle the resident in a safe manner to prevent injuries. The findings include:

    a. Resident #265's diagnoses included hemorraghic stroke and Alzheimer's disease. The assessment dated 6/25/07 identified that the resident was cognitively impaired, was totally dependent on staff for transfer, dressing, personal hygiene and bathing, required extensive assistance of staff for bed mobility and had limited range of motion of the

upper and lower extremities bilaterally.
The care plan dated 7/19/07 noted that the resident was at risk for alteration in skin integrity. Interventions included to turn and position the resident every 2 to 3 hours and to report any open areas.
Nurse's notes dated 8/18/07 identified that the resident had a 3 cm by 2 cm open area on the front of the left shin. Physician's orders dated 8/18/07 directed that the left shin skin tear be cleansed with normal saline and covered with Xeroform daily for 14 days.
Wound assessments by the APRN on 8/6/07 identified a new wound on the top of the left second toe. On 8/9/07, the APRN ordered Keflex to treat a wound infection of the toe. On 8/17/07, the APRN documents that the wound was a Stage IV due to overlapping of the toes. On 8/27/07, the APRN ordered Tylenol for pain due to the toe, and ordered Keflex.
A physician progress note dated 9/10/07 identified that the resident's second toe on the left foot was noted to be dangling, painful, and questionably dislocated. An Xray was ordered that identified a fracture of the distal portion of the first phalange of the left second toe.
Interviews with LPN # 4 on 5/2/08 at 11:50 AM, MD#1 on 5/2/08 at 4:30 PM, and RN #7 on 5/8/08 at 1:50 PM identified that the resident had restless movement of the lower extremities. Review of the clinical record and interview with the DNS failed to provide evidence that the origin of the injuries (skin tear and toe wound/fracture) had been investigated/assessed or that interventions to prevent further injuries had been developed/implemented. The resident was sent to an orthopedic surgeon for consultation on 9/14/07 who transferred the resident to the hospital from the office. Hospital records identified that the toe was amputated due to an open fracture with gangrene of the left toe.

b. Resident #172's diagnoses included dehydration, pulmonary embolus, filter implantation, depression, and hiatal hernia. The assessment dated 1/08/08 identified that the resident was moderately cognitively impaired, required total assistance of two staff for transfer and locomotion. The care plan dated 1/10/08 identified a problem related to immobility. Interventions included to transfer safely with the assist of two persons.
Nurse's notes by the Nurse Supervisor dated 4/11/08 at 5:30 PM documented that the resident was observed with a skin tear measuring 0.9 cm x 0.5 cm x 0.3 cm, to the right ankle. The resident was sent to the hospital and returned with five stitches.
Facility documentation noted that when the resident was provided with evening care and socks were removed, the laceration was noted by the NA. The investigation concluded that during transfer, the resident might have accidentally hit the leg against the wheelchair foot rest resulting in a laceration to the shin/ankle. The investigation lacked an assessment of the care provided to the resident prior to the discovery of the laceration.
Interview on 5/01/08 at 10:30 AM with NA#3 and at 10:45 AM with NA #4 the Nurse Aides' caring for the resident on 4/11/08 during the 8 to 4 PM shift noted that although they reported nothing unusual happened, they did not use the gait belt to transfer the

resident. Interview on 5/01/08 at 10:15 PM with Nurse Aide #5 noted that she had transferred the resident back to bed by herself just before dinner. She noted she knew the assignment directed for two staff but she knows that the resident could stand, that she had been taking care of the resident all week, and that she "used her judgment". This night the resident held herself up.

Interview on 5/01/08 at 9:32 AM with the DNS noted that the investigation concluded the skin tear happened during transfer, possibly bumped, because dried blood was noted on the sock. Interview on 5/02/08 at 9:00 AM and review of the facility policy for transfer with the Director of Rehabilitation Services noted that an object or something was in the way to cause the skin tear. She also noted that the resident should have been an assist of two to transfer for safety for the resident and staff and that gait belt should be used per policy. Interview on 5/02/08 at 11:00 AM and review of the

c. Resident #143 was admitted to the facility on 11/11/07 with diagnoses that included recent alcohol abuse/dependency and a fall with rib fractures. The resident was being followed by Elderly Protective Services (EPS) and admitted to the facility while a suitable place to live was researched by EPS. On 11/12/07 during the 12 AM to 8 AM shift, nurse's notes identify that the resident was restless and wandering the halls. The resident was noted going into other resident's rooms and had to be redirected. At 7:30 AM nurse's notes identify that the resident was noted to be missing from the unit. The supervisor was notified and a missing person policy initiated. Subsequent nursing notes for 11/12/08 indicated that the resident was returned to the facility after being found at McDonald's.

Interview and review of the clinical record and facility documentation with the DNS on 5/1/08 at 11 AM failed to provide evidence that the resident's risk for elopement had been assessed, and/or that interventions to prevent the elopement had taken place when the resident was observed during the night to be restless and wandering into other resident's rooms.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (q) Dietary Services (2).

14. Based on clinical record review, and interview for one of three sampled residents with weight loss (Resident #263), the facility failed to ensure that resident's at risk for weight loss and/or with actual weight loss, received assessments and interventions to attempt to prevent further weight loss. The findings include:

    a. Resident #263 was admitted to facility on 04/11/08 with diagnoses that included cerebral vascular accident (CVA), dementia and de-conditioning. An admission assessment dated 04/15/08 identified the resident was severely cognitively impaired, totally dependent on facility staff for all activities of daily living including eating, weighed ninety eight pounds (98 #'s) and had three (3) stage III pressure ulcers.

    The care plan dated 04/15/08 identified a problem with impaired swallow/dysphagia as evidenced by refusal to eat and related to CVA. Interventions included to allow ample

time to eat and masticate food properly and monitor for weight changes. An integrated (multidisciplinary) admission assessment dated 04/11/08 at 6:05 PM identified that the resident weighed 98 pounds. The "nutritional risk assessment" portion of the admission assessment remained incomplete as of 4/28/08.
Interview and review of R#263 clinical record with ADNS on 4/28/08 at 11:45 AM, indicated that the registered dietician (RD) worked on weekends, and she had not yet assessed the resident's needs nutritionally.
Subsequent to surveyor inquiry, physician orders were obtained on 04/29/08 to provide ensure plus supplement, one can by mouth twice a day, weekly weights and a dietary consult.
A reweigh of the resident on 04/30/08 noted a weight of 92.7 pounds or a loss of 5.3 pounds (5.4% in 3 weeks).
The dietitian assessed the resident on 05/03/08 and identified that the resident was at high nutritional risk. The dietitian's assessment failed to identify the recent weigh loss or the new weight of 92.7 pounds.
Interview with the RD on 5/6/08 at 9:35 AM, identified that she was not aware of the resident's weight loss because the weight was not available in the record and she had not been informed by anyone of the weight loss. She further noted that she had been unable to keep up with evaluations such as Resident #263's because she had resigned in February 2008 and was only working per diem on weekends at the facility.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2).

15. Based on review of the clinical record and staff interview for one of three sampled residents (Resident #63) at risk for dehydration, the facility failed to implement care plan interventions to prevent dehydration. The findings include:
    a. Resident #63's diagnoses included syncope, heart block, hypertension and Parkinson's disease. The assessment dated 2/7/08 identified that the resident was cognitively impaired, required limited assistance of staff for activities of daily living and had no behavior or mood indicators. A dehydration risk assessment dated 1/30/08 identified that the resident was at moderate risk for dehydration. The care plan dated originally dated 1/31/08 and updated through 2/19/08 identified the potential for fluid volume deficits/dehydration. Interventions included to record intake and monitor saliva pools and mucous membranes.
    The dietitian assessment dated 2/4/08 identified that the resident required between 1575-1890 cc of fluid per day and that the resident had been experiencing diarrhea.
    Nurse's notes dated 2/20/08 for the day shift indicated that the resident was agitated and confused and had called the police for help. The resident's psychiatrist was called and ordered Seroquel for agitation. At 9:15 PM, the resident was found lethargic and ashen in color. The blood pressure was 81/56. The attending was notified and the resident transferred to the hospital.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Multiple requests to review intake and output records for the resident resulted in only 5 days provided for review; February 2, 3, 4, 5, and 10, 2008. Only one day was totaled and complete and output was not monitored even though the resident was continent. The emergency department records dated 2/21/08 identified that the resident received 1 liter of normal saline intravenous fluid bolus over one hour and was placed on fluids at 110 cc per hour after the bolus for dehydration and was returned to the facility. Review of the clinical record and interview with the Director of Nursing on 5/8/08 at 3:15PM failed to provide evidence that the resident's intake and output had been consistently monitored and/or assessed and/or documented, or that physical assessments for signs of dehydration had been completed/documented as directed by the care plan.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

16. Based on clinical record review, observation and interview for the only sampled resident receiving intravenous (IV) therapy (Resident #183), the facility failed to administer IV antibiotic per physician orders and/ or ensure proper monitoring/utilization of IV equipment was implemented. The findings include:
    a. Resident #183 was admitted on 4/01/08 with diagnoses that included A-fib, Ecoli bacteremia, and pneumonia. Physician orders dated 4/23/08 directed the administration of Unasyn 3 g IV every 8 hours for 10 days for treatment of urosepsis. The resident went to the emergency department and returned on 4/25/08. Physician orders dated 4/25/08 directed to continue with Unasyn IV as before. The peripheral line utilized for the IV antibiotic was inserted into the left arm by the IV Nurse on 4/25/08.
        i. Observation of the resident on 5/02/08 at 11:51 AM noted a peripheral IV access site to the back of the left hand. The IV site was labeled "4/25/08 2200." The peripheral IV was infusing per pump at 75 ml per hour. An additional IV bag of 100 ml of 0.9 % sodium chloride with Unasyn 3g was infusing via gravity drip; about 20-25 ml remained in the bag. The bag directed for the antibiotic to infuse (100 ml) over one hour. The bag was dated/labeled as having been hung up on "5/02/08 - 6 AM."
        ii. Observation on 5/02/08 at 1:05 PM, with RN#6 noted the Unasyn was dated and hung on 5/02/08 at 6:00 AM and was just finishing infusing (7 hours later). Interview at that time noted that she had monitored only the IV hydration and not the antibiotic. AT 2:20 PM, RN#6 noted she was awaiting a return call from the physician to direct the next antibiotic administration time.
        iii. Interview and review of the IV policy for IV Monitoring with the ADNS on 5/02/08 at 2:01 PM noted that per policy the IV peripheral line is to be rotated every 72-96 hours (3 to 4 days). Subsequent to surveyor inquiry, the IV needle that had been inserted and left in for 7 days was to be changed.

The following are violations of the Regulations of Connecituct State Agencies Section 19-13-D8t (j)

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

17. Based on review of clinical records, observations, and staff interviews for four of ten residents observed receiving medications (Residents #23, 35, 37, 74), the facility failed to administer the medications at the correct time, and /or in the correct dose, and/or according to physician orders, and/or according to standards of practice resulting in the medication error rate calculated at 19%. The findings include:
    a. Resident #23's diagnoses included diabetes and congestive heart failure.
        i. Resident #23's physician orders dated 4/4/08 directed that Lasix 60 mg be administered once a day. Observation on 4/30/08 at 12:30 PM noted the nurse placing 20 mg of Lasix in the medication cup and preparing to administer the medication to the resident. Subsequent to surveyor inquiry, the nurse placed 40 mg more into the cup to equal the correct dosage of 60 mg.
        ii. Resident #23's physician orders dated 4/04/08 directed the administration of a Flovent inhaler two puffs twice a day, at 10:00 AM and 6 PM, Robitussin DM syrup 10 ml. twice a day at 10:00 AM and 5 PM, Norvasc 5 mg daily at 10:30 AM, Celebrex 100mg daily at 10:30 AM, Lisinopril 20mg daily at 10:30 AM, potassium chloride SA 20 meq daily at 10:30 AM, Coreg 12.5 mg. twice a day at 10:00 AM and 9 PM, and Lasix 60 mg daily at 10:30 AM. Observation of medication administration on 4/30/08 at 12:30 PM identified that the medication nurse was still administering the morning (10 AM and 10:30 AM) medications. Interview with the medication nurse at that time noted that there was to be a second nurse on the floor with her, but they were working short. The nurse identified that the medication was late and was being administered at the wrong time.
    b. Resident #74's diagnoses included end stage coronary artery disease, and status post myocardial infarction (two times). Physician orders dated 4/28/08 directed to administer aspirin 81 mg tablet, chewable one tablet daily. Observation of medication administration on 4/28/08 at 8:44 AM identified that an enteric coated 81 mg aspirin was crushed and administered to the resident. During an interview with LPN #1 on 4/28/08 at 8:56 AM, she indicated that chewable aspirin was not available in her cart and she used the enteric coated aspirin in error. During an interview with Pharmacist #1 on 5/5/08 at 10:15 AM, she indicated that enteric coated aspirin should not be crushed secondary to diminishing its protective effect.
    c. Resident #37's diagnoses included chronic obstructive pulmonary disease (COPD), emphysema and bronchitis. Physician orders dated 4/4/08 directed to administer Ventolin metered dose inhaler (MDI) two (2) puffs and Atrovent HFA MDI two (2) puffs by mouth three times per day. Observation on 4/28/08 noted RN #1 administrating medications to resident #37. RN #1 administered Atrovent MDI two puffs and then immediately administered two puffs of Albuterol MDI. During a interview with RN #1 on 4/28/08 at 9:40 A.M. she indicated that the reason she did not wait between administration of the MDI's inhalers was secondary to the physician directions to administer at 9:00 AM. Interview with Pharmacist #1 on 5/5/08 at 10:15 AM indicated that Albuterol (an

broncho-dilator) should be administered first, waiting 3 to 5 minutes between each puff and then after waiting 3 to 5 minutes more before administering the subsequent MDI, Atrovent.

d. Resident #35's diagnosis included acute heart attack. Physician orders dated 4/03/08 directed Nitroglycerin patch 0.2 mg/hr, apply one patch topically every morning and remove every evening; on at 6:00 AM and off at 6:00 PM. Observation of medication administration on 4/28/08 at 8:30 AM noted the night Nurse, LPN#5, removed the old nitroglycerin patch (applied the previous day) and applied the new nitroglycerin patch to the resident one and one half hours beyond acceptable time parameters. Interview with the LPN at that time noted that he was the only licensed nurse on the unit and did not expect so many medications for 6:00 AM administration. Interview on 4/30/08 at approximately 11:30 AM and review of the physician orders with Unit Manager #4 noted that the medication should have been given as scheduled and that the old patch should have been removed at 6:00 PM.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (j) Director of Nurses (2) and/or (m) Nursing Staff (1).

18. Based on observation, facility documentation and staff interview, the facility failed to maintain sufficient nursing staff to provide proper nursing care and services to the residents. The findings include:

a. Interview with several staff members on 4/28/08 at 8:30 AM, and residents and families throughout the survey identified that the facility was understaffed. Further interview identified that on 4/20/08, Unit 4 failed to have a licensed nurse continuously staff the unit during the 8 AM - 4 PM shift.

Interview with the RN supervisor on 4/30/08 at 12 PM identified that she was scheduled to work the 4 PM - 12 AM shift on 4/19/08. During the shift the supervisor learned that the 12 AM - 8 AM shift was going to be short 2 nurses. She was able to find one replacement and volunteered to work a second shift to provide proper licensed staff coverage. During the 12 AM - 8 AM shift she learned that the facility would again be short one licensed staff for the day shift. Additionally, at 8 AM the scheduled agency nurse was a no-call, no-show, resulting in a shortage of 2 licensed staff. The supervisor called the agencies, DON, ADON and several staff nurses but failed to get coverage. The DON asked the supervisor to remain in the facility until she could get to the facility. The RN supervisor agreed and began her third consecutive shift. The RN supervisor worked one unit and attempted to make herself available to the other units which were staffed by agency LPN's (one on each floor). She was unable to provide continuous nurse coverage to Unit 4. Further interview identified that scheduled medications were not administered to approximately 33 residents and none of the treatments for Unit 4 had been completed. The supervisor noted that she called the DON several times to find out where she was, but that relief did not come to the facility until between 1 and 2 PM. The supervisor noted that she had volunteered to work the 4 PM-12 PM shift on

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Saturday, 4/19/08, which was her weekend off, because the staffing was so poor. She further noted that although she tried to give all the insulins and cardiac medications to the residents of the 4th floor, she was so tired that she could no longer read or hold her head up. She stayed in the facility until the DON arrived in the afternoon.

b. As a result of #1 above, Resident #47 who had been experiencing respiratory symptoms, was not assessed on 4/20/08 from 7 AM until 11:15 PM.

c. As a result of #1 above, Resident #36 who had been experiencing respiratory symptoms, was not assessed on 4/20/08 from 6 AM until 11:15 PM.

d. On 4/30/08 Resident #23's medication administration that was ordered by the physician to be given at 10 AM, were observed being administered at 12:30 PM. The medication nurse was still administering the morning (10 AM and 10:30 AM) medications at that time. Interview with the medication nurse at that time noted that there was to be a second nurse on the floor with her, but they were working short. The nurse identified that the medication was late and administered at the wrong time.

e. On 4/30/08 Resident #35's medication administration that was ordered by the physician to be given at 6 AM, were observed being administered at 8:30 AM. Interview with the LPN at that time noted that he was the only licensed nurse on the unit and did not expect so many medications for 6:00 AM administration.

f. Resident #252 was admitted to facility on 03/11/08 with diagnoses that included traumatic brain injury (TBI). A re-admission integrated (interdisciplinary) assessment dated 4/13/08 identified the presence of pressure ulcers, but failed to identify location, size and/or characteristics of the pressure sores.

A Nurse practitioner note dated 04/17/08 identified stage two pressure sores on each buttock, and on 04/23/08 a new open area was identified on the scrotum.

Observation of resident on 5/4/08 from 6:37 AM through 9:25 AM (2 hours 48 minutes) noted that the resident remained positioned on the back without the benefit of repositioning or an incontinence check.

During an interview with NA#1 on 5/6/08 at 12:05 PM, identified that her shift began at 8:00 AM, that it was a very busy day and it was difficult to take care of everyone.

g. Both the DNS and supervisor noted that the facility lacked a system of on call nursing staff to cover emergencies and had limited access to agencies. Further interview noted that most of the nursing staff had left when management of the facility changed hands at the beginning of 2008. Significant staffing cuts were initiated by the new owners and registered nurse wages cut $5.00 per hour.

h. Interview with the administrator on 5/8/08 at 12:15 PM identified that he was called by the DNS on 4/20/08, midmorning, and she explained at that time that there was a staffing issue, but that she would go to the facility and look into the situation and said to the administrator "I have it covered". According to the administrator, the next call he received was from the maintenance man at 1 PM who informed him that a nursing supervisor had worked in the building for twenty four hours straight and was still there. When he arrived at the facility around 4 PM, both the DNS and the ADNS were there. According to the administrator, he was not aware that treatment and medications were omitted, nor was he

aware that the DNS or ADNS were not immediately available to handle a staffing crisis, both having arrived sometime in the afternoon. In addition, the administrator identified that if there was a staffing issue, he would have expected the DNS to report it to him.

i. Resident #93 diagnoses include implanted defibrillator, angioplasty with stent insertion, coronary artery disease, atrial fibrillation, chest pain, and congestive heart failure with an ejection fraction of 25%. An assessment dated 4/8/08 identified the resident to be without cognitive impairment and requiring limited assistance with activities of daily living. A care plan dated 5/8/08 identified an alteration in cardiac function as evidenced by chest pain and anxiety. Interventions included minimizing agitation or situations which cause anxiety. The care plan directed that nitroglycerin be administered for chest pain.

Interview with Resident #93 on 4/30/08 at 11:00 AM identified that at approximately 9:45 AM on 4/20/08, he was experiencing chest pain and needed the nitroglycerin to relieve it. He/she reported that a nurse aide came to the room and said she would get the supervisor. According to the resident, there was no nurse available on the unit and he had to wait forty five minutes before a nurse came to his room and administered the medication/Nitroglycerin. The resident identified that he had concerns regarding the staffing of licensed nurses.

In a written statement from Supervisor #1, she noted that due to the failure to schedule an adequate number of licensed nurses for the weekend of 4/19, 20/08, and callouts and no shows from the agencies that were booked, the facility was without a nurse on the fourth floor during the 8-4pm shift on 4/20/08. She had attempted every nurse on staff and agencies to fill the vacancies without success. She called the DNS several times who told her she would be there later. The ADNS was called and did not return the phone calls.

The supervisor explained that she had expected the DNS to arrive at the facility around 11 AM, following an early morning conversation that she had with the DNS. She was in the office resting when she was called to the 4th floor sometime after 10 AM by a nurse aide who reported that Resident #93 was having chest pain. Supervisor #1 noted that she arrived on the 4th floor at that time and administered the nitroglycerin to Resident #93 three times before the chest pain subsided. She noted that she stayed with the resident for a while and held his/her hand. She noted it was approximately 11:45 AM when she gave the resident the other scheduled medications that had been ordered for 9-9:30 AM.

Interview with the DNS on 4/30/08 at 9:30 AM noted that although she was aware of the insufficient licensed staff, and the fact that the supervisor had been on duty for the 3rd straight shift, she was not able to come to the facility until the afternoon. She stated that the ADNS was unable to come into the facility because she had no car and no one to watch her children.

Interview with the medical director on 5/15/08 and review of the delayed response to the administration of nitroglycerin on 4/2/08 identified that he would think that the delay in receiving medications would have caused increased anxiety related to the nurse not being on the floor.

EXHIBIT A

DATES OF VISITS: April 28, 29, 30, May 1, 2, 3, 5, 6 and 7, 2008

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (n) Medical and Professional Services (5)(A).

19. Based on clinical record review, and interview the facility failed to ensure that resident's were visited/assessed by the physician and/or the medical director at least every 60 days. The findings include:
    a. Review of Resident #110's physician orders and progress notes identified that the resident was not seen/assessed by a physician since 1/10/08.
    b. Review of Resident #2's physician orders and progress notes identified that the resident was not seen by a physician from 1/25/08 until 5/1/08, at which time, the facility APRN signed the physician orders.
    Interview with the medical director on 5/14/08 at 9 AM noted that he was not made aware of the lack of physician visits; he noted that he depended on staff to notify him and he would see the patient, and call their attending to remind them.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (s) Social Work (2).

20. Based on review of clinical records, and staff interviews for one of two residents in the survey sample who were non-English speaking and/or had difficulty communicating with staff (Resident #51), the facility failed to provide the resident with a communication board or other mechanism of communication to facilitate the staff's ability to understand the resident's needs resulting in frustration of the resident with getting needs met. The findings include:
    a. Resident #51's diagnoses included cerebral vascular accident and left hemiplegia. An admission assessment dated 12/12/07 identified the resident to be without cognitive impairment and totally dependent on staff for activities of daily living. Psychiatric progress notes dated 2/7/08 and 3/6/08 identified that the resident's family had reported that the resident was upset because she could not communicate and "stuck out" secondary to the frustration and inability to be understood by the staff.
    A care plan dated 3/18/08 identified that the resident was resistive to care, aggressive and physically abusive. Interventions included to explain the adverse effects to the resident of non-compliance with the treatment/plan of care.
    On 5/2/08 at 8:45 AM while interviewing the charge nurse, it was noted that the resident was often frustrated secondary to a language barrier (speaks only Spanish). The charge nurse further stated that the housekeeper on the 8-4 shift interprets the Spanish language for the nurse. According to the charge nurse, she had spoken to the speech therapist about a month prior about creating a communication board, which the therapist said she would do.
    Interview with the speech therapist on 5/2/08 at 11 AM noted that she had not provided the communication board due to lack of time and staff. Interview with the director of rehabilitation on 5/2/08 at 11:15 AM identified that she was not aware of the speech

therapist's inability to provide the communication board and if she had known, she would have found a way meet the resident's needs in a more timely manner.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A).

21. Based on a review of clinical records, observations and staff interviews, for two of three residents in the survey sample with a need for dental services (Residents #51, #25), the facility failed to have a system in place for scheduling/tracking dental services and ensuring that residents in need receive the services. The findings include:
    a. Resident #51's diagnoses included cerebral vascular accident and left hemiplegia. An admission assessment dated 12/12/07 identified the resident to be without cognitive impairment and totally dependent on staff for activities of daily living.
    Facility documentation dated 12/20/08 identified that the resident's family requested the resident be seen by a dentist. Dental service records dated 3/30/08 identified that the resident was not seen until that date with recommendations which included the extraction of several teeth.
    Observations of the resident on 5/2/08 at 10:30 AM noted the resident to have several missing and chipped teeth.
    b. Resident #25's diagnoses included diabetes. An assessment dated 2/14/08 identified the resident to be without cognitive impairment and totally dependent on staff for activities of daily living.
    Observation of the resident on 4/28/08 at 11:30 AM noted the resident to have missing teeth and many remaining teeth were badly stained.
    Review of the clinical record at that time with the charge nurse, identified that the resident had not been examined by a dentist since 2006 and should have been examined by a dentist at least yearly.
    Interview with the corporate nurse on 5/2/08 at 10:30 AM, identified that neither Resident #25 or #51 had been seen timely because the facility had no system in place for the identification and scheduling of resident's yearly appointments. The facility was unable to provide evidence of a method for tracking/scheduling residents with dental problems that are in need of immediate interventions.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (t) Infection Control (2).

22. Based on review of the infection control program and staff interview, the facility failed to analyze infection control data resulting in a failure to identify trends and implement corrective measures if and when appropriate, and/or the facility failed to provide evidence that a recent quarterly infection control meeting had been held, and/or the facility failed to ensure that contaminated items were cleaned appropriately including equipment and hands. The findings include:
    a. Review of the infection control data from 12/07 through current (5/6/08) with the

corporate nurse on 5/6/08 at 11:30 AM identified that although infection control and trending policies and procedures were available in the facility for implementation by staff, the nursing department had not yet implemented them.
Interview with the director of nursing on 5/8/08 at 10:00 AM and review of the monthly infection statistics, identified that although percentage of infections are noted on reports that are forwarded to the corporation staff:

i. The facility failed to conduct an analysis of the gathered statistics to determine trends;
ii The facility failed to plan and conduct a quarterly infection control meeting with the medical board staff;
iii The facility failed to keep current, ongoing line listings of all residents with a history of VRE, C-Diff and/or MRSA infection and/or colonizations.

b. Observation on 4/28/08 at 9:10 AM, noted RN #1 preparing medications on the medication cart for Resident #37. RN#1 dropped the MDI cover on the floor twice, then dropped a medication cup. She then picked them up off the floor and placed them back on her cart without the benefit of cleaning the covers and/or washing her hands.
During interview on 4/28/08 at 9:40 AM she indicated that she was unable to explain why she picked items off floor without cleaning them and/or washing hands. She further indicated that although she usually used hand sanitizer, there was none available on the med cart.

23. Based on observations and interviews for one of ten residents observed for medication administration (Resident #37), the facility failed to ensure that staff washed hands when potentially contaminated. The findings include:

a. Observation on 4/28/08 at 9:10 AM, noted RN #1 preparing medications on the medication cart for Resident #37. RN#1 dropped the MDI cover on the floor twice, then dropped a medication cup. She then picked them up off the floor and placed them back on her cart and without the benefit of washing her hands, continued passing out the medication to the resident.
b. During interview on 4/28/08 at 9:40 AM she indicated that she was unable to explain why she picked items off floor without washing hands. She further indicated that although she usually used hand sanitizer, there was none available on the med cart.
c. During an interview with the corporate nurse and the ADNS on 04/29/08 at 12:03 PM, they indicated that hands should be washed between residents and/or coming in contact with contaminated items.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1) and/or (f) Administrator (3).

24. Based on review of facility documentation, observations and staff interviews, the administration and/or ownership of the facility failed to provide adequate support services and resources to ensure that every resident received appropriate care and services. The findings include:

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

a. The facility administration/ownership failed to ensure:
   i. That a system for determining acuity was developed and/or completed prior to establishing lower staffing patterns than that which had been in place at the time they took over the facility resulting in significant quality of care deficiencies.
   ii. That dietitian services were available to meet the needs of the residents.
   iii. That social services were available and provided to resident's who needed them.
   iv. That MDS assessment coordinators and/or alternatives were in place to ensure accurate and timely assessments for new residents.
   v. That adequate nursing staffing was provided to ensure that resident needs were met.
   vi. That the computerized flow sheet system (Care Tracker) was maintained and functional and/or that resident specific clinical data was available in another form.
   vii. That emergency phone numbers were available to nursing supervisors to utilize when significant issues were identified and the DNS and ADNS failed to respond to the needs of the facility residents.
   viii. That medical staff meetings were held quarterly, and that the medical staff approved of all the new policies brought in by the new ownership prior to attempting to implement the policies.
   ix. That physicians with privileges to care for residents at the facility were credentialed.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (i) Medical Staff (1)(2)(3)(4)(5) and/or (m) Nursing Staff (3) and/or (q) Dietary Services (3)(b) and/or Section 19-13-D8u.

25. Based on staff interviews and survey results, the facility administrator and DNS failed to provide care and services in accordance with the Regulations of Connecticut State Agencies (Public Health Code) to ensure quality of care to the residents. The findings include:
   a. Interview with the Administrator and DON on 5/1/08 at 11:30 AM identified that they failed to meet monthly to discuss and determine the number, experience and qualifications of staffing needs in accordance with section 19-13-D8t (m) (3) of the Connecticut Public Health Code.
   b. The facility failed to comply with Public Health Code (q) Dietary Services (3)(b) that directs the facility ensure adequate registered Dietician services to meet the needs of facility residents as evidenced by, Resident #263 failed to be assessed by the dietitian (RD) from 4/11/08 until subsequent to surveyor inquiry on 5/3/08. The resident had experienced a significant weight loss over a 3 week post admission period during which no interventions were initiated. Interview with the RD on 5/6/08 at 9:35 AM, indicated that she was unaware of the resident weight change and that she was unable to keep up with evaluations such as Resident #263's because she had resigned in February 2008 and was only working per diem on weekends at the facility.
   c. Interview and review of the facility documentation on 5/02/08 at 11:00 AM with the DNS noted that she was unable to provide evidence that licensed staff providing care to residents receiving IV Therapy had received training and/or certification and/or

competency evaluations in accordance with section 19-13-D8u (c)(1)(C) of the Connecticut Public Health Code.

d. IV policies for the monitoring of therapy and sites, staff education, inservice, certification, and other training, and other policies were not in the policy manual in accordance with the Public Health Code. The facility manual lacked approval of a formulary, the goal, and scope of the IV program, and a list of responsibilities in accordance with section 19-13-D8t (c)(1)(C) of the Connecticut Public Health Code.
e. Interview and review of the facility menu cycle/breakdown menus with the Food Service Director (FSD) on 4/30/08 at 12:25 PM failed to provide evidence that the Registered Dietician (RD) had assessed and approved of the menus in accordance with section 19-13-D8t (q)(3)(B) of the Connecticut Public Health Code.
f. Interview with the Administrator on 5/1/08 at 11:30 AM identified that they failed to have medical staff by laws, meetings, and/or credentials, and/or approval of appointments to the medical staff in writing, in accordance with section 19-13-D8t (i) of the Connecticut Public Health Code.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (e) Governing Body (1).

26. Based upon interviews, the facility failed to have a governing body in place that developed by laws and appointed qualified staff to manage the facility. The findings include:
    a. Interview with the Corporate Vice President on 5/6/08 at 12:45 p.m. identified that there had been no governing body and no by-laws in the facility established since the company purchased the facility in December 2007. Neither the administrator or the Vice President were aware of the need for a governing body

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

27. Based on interviews, the facility failed to ensure that nurse aide skills were evaluated to determine their competency. The findings include:
    a. Request to review competency evaluations for nurse aides were unmet. Interview with the ADNS on 5/5/08 noted that she had not had the time to do inservice education because she was also responsible for the oversight of a unit on the day shift and infection control.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (1).

28. Based on clinical record reviews, and interviews, for two residents (Resident #63, #61) the facility failed to ensure that medical records were always available, and/or complete.
    a. Resident #63 had diagnoses that included that included syncope, heart block,

hypertension and Parkinson's disease. Physician orders dated 2/15/08 directed that the resident be given Lamictal 25 mg. by mouth every morning starting on 2/15/08 for 2 weeks then Lamictal 50 mg. by mouth every morning for 2 weeks and Lamictal 100 mg. by mouth every morning. Interview with RN #7 on 5/2/08 at 11:45 am identified that the Lamictal orders had been transcribed from a prescription from MD # 2. Review of the clinical record with the Director of Nursing on 5/2/08 at 11:30 AM failed to provide evidence of any consultation with MD #2.

b. Resident #61 was admitted on 11/11/07. Multiple requests to view flow sheets for November 2007 were not met. Interview on 5/02/08 at 11:35 AM with the DNS noted that the November 2007 flow records were documented in the electronic/computerized care tracker. She identified that the care tracker went down and all data was wiped out. The November 2007 flow sheet documentation is not available.
Interview with the former administrator on 5/8/08 at 1 PM identified that the computer system remained at the facility with the new owners. She noted that the system required an upgrade in order to maintain functionality and that she had scheduled that upgrade prior to leaving the position at the end of January 2008. She indicated that without the upgrade, all of the data would be inaccessible including resident records.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (u) Emergency Preparedness Plan (5).

29. Based on review of facility documentation and staff interview, for four employees recently hired by the facility, review of the employee files could not provide evidence that the employees were provided with fire and disaster training. The findings include:
    a. Upon review of employee files for RNs #5 and #6, the social worker and central supply clerk who were newly hired, the facility failed to provide evidence that orientation for fire and disaster had been provided. According to the ADNS on 5/5/08 at 10:15 AM, who was also the staff development coordinator, due to lack of staffing within the facility, she was unable to find the time to provide the inservices needed.

EXHIBIT B
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FLIS Independent Nurse Consultant Guidelines

Relationship between Independent Nurse Consultant (INC) and DPH includes:

- An INC is utilized as a component of DPH's regulatory remedy process. An INC may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and service issues are identified.
- The INC has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The INC's responsibilities include:
  - Reporting to the Department issues and concerns regarding quality of care and services being provided by the institution.
  - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
  - Assessing administration's ability to manage and the care/services being provided by staff.
  - Weekly reporting to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between INC and the Institution:

- The INC maintains a professional and objective relationship with the institutional staff. The INC is a consultant, not an employee of the institution. The INC exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the INC but must cooperate with and respond to requests of the INC related to her fulfilling her/his duties.
- The INC's responsibilities include:
  - Assessment of staff in carrying out their roles of administration, supervision and education.
  - Assessment of institution's compliance with federal/state laws and regulations.
  - Recommendations to institutional administration regarding staff performance.
  - Monitoring of care/services being provided.
  - Assists staff with plans of action to enhance care and services within the institution.
  - Recommendation of staff changes based on observations and regulatory issues.
  - Weekly reports to the institution re: assessments, issues identified, and monitoring of plans of correction.
  - Promotes staff growth and accountability.
  - May present some inservices but primary function is to develop facility resources to function independently.
  - Educates staff regarding federal/state laws and regulations.